SERFF Tracking Number:	*AMFA-126175337*	*State:*	*Arkansas*
Filing Company:	*Ameritas Life Insurance Corp.*	*State Tracking Number:*	*42567*
Company Tracking Number:	*USA+*		
TOI:	*H10G Group Health - Dental*	*Sub-TOI:*	*H10G.000 Health - Dental*
Product Name:	*USA+*		
Project Name/Number:	*USA+/USA+*		

Filing at a Glance

Company: Ameritas Life Insurance Corp.

Product Name: USA+
TOI: H10G Group Health - Dental
Sub-TOI: H10G.000 Health - Dental
Filing Type: Form

SERFF Tr Num: AMFA-126175337
SERFF Status: Closed
Co Tr Num: USA+
Co Status:
Author: Janis Landon
Date Submitted: 06/03/2009

State: ArkansasLH
State Tr Num: 42567
State Status: Approved-Closed
Reviewer(s): Rosalind Minor
Disposition Date: 06/04/2009
Disposition Status: Approved-Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name: USA+
Project Number: USA+
Requested Filing Mode: Review & Approval
Explanation for Combination/Other:
Submission Type: New Submission
Overall Rate Impact:
Filing Status Changed: 06/04/2009

Status of Filing in Domicile: Not Filed
Date Approved in Domicile:
Domicile Status Comments:
Market Type: Group
Group Market Size: Large
Group Market Type: Association
Explanation for Other Group Market Type:
State Status Changed: 06/04/2009
Corresponding Filing Tracking Number:

Deemer Date:

Filing Description:

June 3, 2009

Arkansas Department of Insurance

RE: Out-of-State Group Insurance Plan
USA+

SERFF Tracking Number:	*AMFA-126175337*	*State:*	*Arkansas*
Filing Company:	*Ameritas Life Insurance Corp.*	*State Tracking Number:*	*42567*
Company Tracking Number:	*USA+*		
TOI:	*H10G Group Health - Dental*	*Sub-TOI:*	*H10G.000 Health - Dental*
Product Name:	*USA+*		
Project Name/Number:	*USA+/USA+*		

Dear Sir/Madam:

Ameritas Life Insurance Corp. (“Ameritas”) is an Arkansas licensed insurer and has recently issued a group policy providing dental and eye care benefits to the members of the United Service Association for Healthcare, sitused in Washington, D.C. The association has members who may be resident of your state.

Therefore, we are requesting the Department’s approval of this association group as an out-of-state group. All supporting documents required by your state have been attached for your review.

Thank you for your review of this filing. If you need anything additional, please feel free to contact me at 800-745-1112, ext.82444, FAX 402-309-2573 or email jlandon@ameritas.com.

Sincerely,

Janis Landon
Senior Contract Analyst

Company and Contact

Filing Contact Information

Janis Landon, Contract Analyst	jlandon@ameritas.com	
5900 O Street	(800) 745-1112 [Phone]	
Lincoln, NE 68501-1889	(402) 467-7956[FAX]	

Filing Company Information

Ameritas Life Insurance Corp.	CoCode: 61301	State of Domicile: Nebraska
5900 O Street	Group Code: 943	Company Type:
P O Box 81889		
Lincoln, NE 68501-1889	Group Name:	State ID Number:
(800) 756-1112 ext. [Phone]	FEIN Number: 47-0098400	

SERFF Tracking Number:	*AMFA-126175337*	*State:*	*Arkansas*
Filing Company:	*Ameritas Life Insurance Corp.*	*State Tracking Number:*	*42567*
Company Tracking Number:	*USA+*		
TOI:	*H10G Group Health - Dental*	*Sub-TOI:*	*H10G.000 Health - Dental*
Product Name:	*USA+*		
Project Name/Number:	*USA+/USA+*		

Filing Fees

Fee Required?	No
Retaliatory?	No
Fee Explanation:	
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Ameritas Life Insurance Corp.	$0.00	06/03/2009	

SERFF Tracking Number:	*AMFA-126175337*	*State:*	*Arkansas*
Filing Company:	*Ameritas Life Insurance Corp.*	*State Tracking Number:*	*42567*
Company Tracking Number:	*USA+*		
TOI:	*H10G Group Health - Dental*	*Sub-TOI:*	*H10G.000 Health - Dental*
Product Name:	*USA+*		
Project Name/Number:	*USA+/USA+*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	06/04/2009	06/04/2009

SERFF Tracking Number:	*AMFA-126175337*	*State:*	*Arkansas*
Filing Company:	*Ameritas Life Insurance Corp.*	*State Tracking Number:*	*42567*
Company Tracking Number:	*USA+*		
TOI:	*H10G Group Health - Dental*	*Sub-TOI:*	*H10G.000 Health - Dental*
Product Name:	*USA+*		
Project Name/Number:	*USA+/USA+*		

Disposition

Disposition Date: 06/04/2009
Implementation Date:
Status: Approved-Closed
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*AMFA-126175337*	*State:*	*Arkansas*
Filing Company:	*Ameritas Life Insurance Corp.*	*State Tracking Number:*	*42567*
Company Tracking Number:	*USA+*		
TOI:	*H10G Group Health - Dental*	*Sub-TOI:*	*H10G.000 Health - Dental*
Product Name:	*USA+*		
Project Name/Number:	*USA+/USA+*		

Item Type	Item Name	Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	By-laws	Approved-Closed	Yes
Supporting Document	Group Master Policy	Approved-Closed	Yes
Supporting Document	Filing Requirements	Approved-Closed	Yes
Supporting Document	AR Members	Approved-Closed	No
Supporting Document	Financial Statements	Approved-Closed	No

SERFF Tracking Number:	*AMFA-126175337*	*State:*	*Arkansas*
Filing Company:	*Ameritas Life Insurance Corp.*	*State Tracking Number:*	*42567*
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TOI:	*H10G Group Health - Dental*	*Sub-TOI:*	*H10G.000 Health - Dental*
Product Name:	*USA+*		
Project Name/Number:	*USA+/USA+*		

Rate Information

Rate data does NOT apply to filing.

SERFF Tracking Number:	*AMFA-126175337*	*State:*	*Arkansas*
Filing Company:	*Ameritas Life Insurance Corp.*	*State Tracking Number:*	*42567*
Company Tracking Number:	*USA+*		
TOI:	*H10G Group Health - Dental*	*Sub-TOI:*	*H10G.000 Health - Dental*
Product Name:	*USA+*		
Project Name/Number:	*USA+/USA+*		

Supporting Document Schedules

Review Status:

Bypassed -Name: Flesch Certification — Approved-Closed — 06/04/2009
Bypass Reason: n/a
Comments:

Review Status:

Bypassed -Name: Application — Approved-Closed — 06/04/2009
Bypass Reason: n/a
Comments:

Review Status:

Satisfied -Name: By-laws — Approved-Closed — 06/04/2009
Comments:
Attachment:
bylaws-042109.pdf

Review Status:

Satisfied -Name: Group Master Policy — Approved-Closed — 06/04/2009
Comments:
Attachment:
9000 policy.pdf

Review Status:

Satisfied -Name: Filing Requirements — Approved-Closed — 06/04/2009
Comments:
Attachment:
Association Refiling.Ameritas.pdf

BYLAWS

OF

UNITED SERVICE ASSOCIATION FOR HEALTH CARE

These Bylaws (referred to as the "Bylaws") govern the affairs of United Service Association For Health Care, a non-profit corporation (hereinafter referred to as the "Corporation") organized and existing under the District of Columbia Non-Profit Corporation Act (hereinafter referred to as the "Act").

ARTICLE 1
OFFICES

1.1 Principal Office. The principal office of the Corporation shall be located at 1901 N. Hwy. 360 Suite 101, Grand Prairie, Texas 75050. The Corporation may have such other offices, either in the District of Columbia, Texas, or elsewhere, as the Board of Directors may determine. The Board of Directors may change the location of any office of the Corporation.

1.2 Registered Office and Registered Agent. The Corporation shall comply with the Act and maintain a registered office and registered agent in the District of Columbia. The Board of Directors may change the registered office and the registered agent as provided in the Act.

ARTICLE 2
MEMBERS

2.1 Class of Members. The Corporation shall have one (1) class of members, consisting of small business employers, employees, and persons who are self-employed, who are interested in and supportive of the purposes for which the Corporation was organized.

2.2 Admission of Members and Renewal of Membership. Members may be admitted to the Corporation by completing an application form, submitting such form to the Corporation, and having the application accepted by the Board of Directors or a committee designated by the Board to handle such matters. The Board of Directors or a Board-designated committee may adopt and amend application procedures and qualifications for membership in the Corporation. An affirmative vote of the Directors or a Board-designated committee present and voting shall be required for admission of any applicant who meets the membership qualifications then in effect. A member which continues to meet all membership qualifications may renew membership by paying all required fees and dues. Neither the Board of Directors nor a Board-designated committee may approve the admission to membership of an applicant who does not meet the membership qualifications then in effect.

2.3 Membership fees and dues. The Board of Directors may set and change the amount of an initiation fee, if any, and the annual dues payable to the Corporation by members. Dues shall be payable in advance on the first day of each fiscal year. The dues for a new member's first year shall be prorated from the first day of the month in which the member is admitted to membership through the end of the fiscal year.

2.4 Voting Rights. Each member shall be entitled to one (1) vote on each matter submitted to a vote of the members.

2.5 Resignation. Any member may resign from the Corporation by submitting a written resignation to the secretary. The resignation need not be accepted by the Corporation to be effective. A member's resignation shall not relieve the member of obligations to pay any dues, assessments, or other charges that had accrued and were unpaid prior to the effective date of the resignation.

2.6 Termination. Membership in the Corporation terminates upon the death of a Member, if an individual, or dissolution, if an organization. In addition the Board of Directors of the Corporation by affirmation vote of two-thirds (2/3) of all of the Directors may suspend or expel a member for cause after an appropriate hearing. Furthermore, a member shall be automatically terminated without notice in the Corporation for nonpayment of dues that are over sixty (60) days delinquent.

2.7 Reinstatement. A former member may submit a written request for reinstatement of membership. The Board of Directors or a committee designated by the Board of Directors to handle the matter may reinstate membership in accordance with the membership qualifications then in effect, on any reasonable terms that the Board of Directors or committee deems appropriate.

2.8 Transfer of Membership. Membership in the Corporation is not transferable or assignable.

2.9 Waiver of Interest in Corporation Property. All real and personal property, including all improvements located on the property, acquired by the Corporation shall be owned by the Corporation. A member shall have no interest in specific property of the Corporation.

ARTICLE 3

MEETINGS OF MEMBERS

3.1 Annual Meeting. Annual meetings of members shall be held between January 1 and June 30 of each year, or at any other time that the Board of Directors designates. At the annual meeting the members shall elect a board of directors, and transact such other business as may properly be brought before the meeting.

3.2 Special Meetings. Special meetings of the members for any purpose or purposes may be called by the President and shall be called by the President or Secretary at the request in writing of a majority of the Board of Directors, or at the request in writing of not less than ten percent (10%) of the members. A request for a special meeting shall state the purpose or purposes of the proposed meeting, and business transacted at any special meeting of members shall be limited to the purposes stated in the notice.

3.3 Notice and Waivers of Notice. (a) Written notice stating the place, day and hour of the meeting and, in the case of a special meeting, the purpose or purposes for which the meeting is called, shall be delivered not less than ten (10) nor more than thirty (30) days from the date of the holding of such meeting. Attendance at meeting shall constitute a waiver of notice, except where the person attends for the express purpose of objecting to the transaction of any business on the ground that the meeting is not lawfully called.

3.4 Record Date. For the purpose of determining members entitled to notice of or to vote at any meeting of members or any adjournment thereof, the Board of Directors may in advance establish a record date which must be at least ten (10) but not more than fifty (50) days prior to such meeting. If the Board of Directors fails to establish a record date, the record date shall be the date on which notice of the meeting is mailed.

3.5 Quorum of Members. The lesser of one hundred (100) members, or members holding five percent (5%) of the votes that may be cast at a meeting, present in person or represented by proxy, shall constitute a quorum at all meetings of the members for the transaction of business except as otherwise provided by statute or by the Articles of Incorporation. If, however, a quorum shall not be present or represented at any meeting of the members, the members entitled to vote thereat, present in person or represented by proxy, shall have power to adjourn the meeting from time to time, without notice other than announcement at the meeting, until a quorum shall be present or represented. At such adjourned meeting, provided a quorum shall be present or represented thereat, any business may be transacted which might have been transacted if the meeting had been held in accordance with the original notice thereof.

3.6 Method of Voting. Each member shall be entitled to one vote on each matter submitted to a vote at a meeting of members. A member may vote either in person or by proxy executed in writing by the member or by his duly authorized attorney-in-fact. No proxy shall be valid after eleven (11) months from the date of its execution, unless otherwise provided in the proxy. Each proxy shall be revocable unless expressly provided therein to be irrevocable and unless otherwise made irrevocable by law.

3.7 Action Without Meetings. The Board of Directors may authorize members to vote by mail on the election of directors and officers or on any other matter that may be voted on by the members, without a meeting. Any action required or which may be taken at a meeting of the members may be taken without a meeting if a consent in writing, setting forth the action so taken, shall be signed by all the members entitled to vote with respect to the subject matter thereof and such consent shall have the same force and effect as a unanimous vote of the members.

ARTICLE 4
DIRECTORS

4.1 Powers. The business and affairs of the Corporation and all corporate powers shall be managed by the Board of Directors, subject to any limitation imposed by statute, the Articles of Incorporation or these Bylaws as to action which requires authorization or approval by the members.

4.2 Number, Qualifications, and Tenure of Directors. The number of Directors which shall constitute the whole Board shall be not less than three (3) or more than nine (9), such number to be determined from time to time by the Board of Directors. Directors shall be members or representatives of the members of the Corporation. Representatives of members may include officers or employees of the employer member. Each Director shall serve until his successor shall have been elected and qualified.

4.3 Nomination of Directors. Candidates for directorship positions on the Board of Directors shall be nominated by existing directors or by a voting member in good standing. Such nominations shall be made at least thirty (30) days prior to any meeting at which the election of a director occurs.

4.4 Election of Directors. A person who meets any qualification requirements to be a director and who has been duly nominated may be elected as a director. Directors shall be elected by the vote of the membership of the Corporation. A director may be elected to succeed himself or herself as director.

4.5 Vacancies. Any vacancy in the Board of Directors caused by death, resignation, removal or otherwise shall be filled through the appointment of a member by a majority of the remaining Directors, even if it is less than a quorum of the Board of Directors. A director elected to fill a vacancy shall be elected for the unexpired term of his predecessor in office.

4.6 Increase or Decrease in Number. The number of Directors may be increased or decreased from time to time by amendment to these Bylaws but no decrease shall have the effect of shortening the term on any incumbent Director. Any directorship to be filled by reason of an increase in the number of Directors shall be filled by election at any annual or special meeting of members.

4.7 Removal of Directors. At any meeting of members called expressly for the purpose of removing a Director, any Director or the entire Board of Directors may be removed, with or without cause, by a vote of majority of the members then entitled to vote at any election of Directors.

ARTICLE 5
MEETINGS OF THE BOARD OF DIRECTORS

5.1 Place. Meetings of the Board of Directors, regular or special, may be held either within or without the State of Texas.

5.2 Regular Meetings. Regular meetings of the Board of Directors may be held upon notice, or without notice unless notice is required under these Bylaws, and at such time and at such place as shall from time to time be determined by the Board.

5.3 Special Meetings. Special meeting of the Board of Directors shall be called by the President. Notice of each special meeting of the Board of Directors shall be given to each Director at least ten (10) days before the date of the meeting.

5.4 Notice and Waiver of Notice. Attendance of a Director at any meeting shall constitute a waiver of notice of such meeting, except where a Director attends for the express purpose of objecting to the transaction of any business on the ground that the meeting is not lawfully called or convened. Except as may be otherwise provided by law or by the Articles of Incorporation or by these Bylaws, neither the business to be transacted at, nor the purpose of, any regular or special meeting of the Board of Directors need be specified in the notice of waiver of notice of such meeting.

5.5 Quorum of Directors. At all meetings of the Board of Directors a majority of the Directors present at any meeting at which there is a Quorum shall be the act of the Board of Directors. If a quorum shall not be present at any meeting of the Directors, the Directors present thereat may adjourn the meeting from time to time, without notice other than announcement at the meeting, until a quorum shall be present.

5.6 Action without Meetings. Any action required or permitted to be taken at a meeting of the Board of Directors or any committee may be taken without a meeting if a

consent in writing, setting forth the action so taken, is signed by all the members of the Board of Directors or committee, as the case may be.

5.7 Committees. The Board of Directors may from time to time designate members of the Board to constitute committees, including an Executive Committee, which shall in each case consist of such number of Directors, not less than two (2), and shall have and may exercise such power, as the Board may determine and specify in the respective resolutions appointing them. A majority of all the members of any such committee may determine its action and fix the time and place of its meeting, unless the Board of Directors shall otherwise provide. The Board of Directors shall have power at any time to change the number, subject as aforesaid, and members of any such committee, to fill vacancies and to discharge any such committee.

ARTICLE 6
OFFICERS

6.1 Election, Number, Qualification, Term, Compensation. The officers of the Corporation shall be elected by the Board of Directors and shall consist of an Executive Director or President, a Vice-President, a Secretary and a Treasurer. The Board of Directors may also elect a Chairman of the Board, additional Vice-Presidents, one or more Assistant Secretaries and Assistant Treasurers and such other officers and assistant officers and agents as it shall deem necessary, who shall hold their offices for such terms and shall have such authority and exercise such powers and perform such duties as shall be determined from time to time by the Board by resolution not inconsistent with these Bylaws. Two (2) or more offices may be held by the same person. None of the officers need be Directors. The Board of Directors shall have the power to enter into contracts, including the employment and compensation of officers for such terms as the Board deems advisable. The salaries of all officers and agents of the Corporation shall be fixed by the Board of Directors.

6.2 Removal. The officers of the Corporation shall hold office until their successors are elected or appointed and qualify, or until their death or until their resignation or removal from office. Any officer elected or appointed by the Board of Directors may be removed at any time by the Board, with or without cause, whenever in its judgment the best interest of the Corporation will be served thereby. Such removal shall be without prejudice to the contract rights, if any, of the person so removed. Election or appointment of an officer shall not of itself create contract rights.

6.3 Vacancies. Any vacancy occurring in any office of the Corporation by death, resignation, removal or otherwise shall be filled by the Board of Directors.

6.4 Authority. Officers and agents shall have such authority and perform such duties in the management of the Corporation as may be provided in these Bylaws or as may be determined by the Board of Directors, not inconsistent with these Bylaws.

6.5 Chairman of the Board. The Chairman of the Board, if one is elected, shall preside at all meetings of the Board of Directors and shall have such other powers and duties as may from time to time be prescribed by the Board of Directors upon written directions given to him pursuant to resolutions duly adopted by the Board of Directors. If, however, the Chairman is not a member or a representative of a member of the Corporation, but is so elected solely by virtue of being an officer of the Corporation, the Chairman shall serve as an *ex officio* Director, without voting powers.

6.6 **Executive Director/President.** The Executive Director, also known as the President, shall be the chief executive officer of the Corporation, shall have general and active management of the business and affairs of the Corporation and shall see that all orders and resolutions of the Board of Directors are carried into effect. The President shall preside at all meetings of the members and at all meetings of the Board of Directors, unless a Chairman of the Board has been elected, in which event the President shall preside at meetings of the Board of Directors in the absence or disability of the Chairman of the Board.

6.7 Vice-President. The Vice-Presidents, in the order of their seniority, unless otherwise determined by the Board of Directors, shall, in the absence or disability of the President, perform the duties and have the authority and exercise the powers of the President. They shall perform such other duties and have such other authority and powers as the Board of Directors may from time to time prescribe or as the President may from time to time delegate.

6.8 Secretary. The Secretary shall attend all meetings of the Board of Directors and all meetings of members and record all of the proceedings of the meetings of the Board of Directors and of the members in a minute book to be kept for that purpose and shall perform like duties for the standing committees when required. He shall give, or cause to be given, notice of all meetings of the members and special meetings of the Board of Directors, and shall perform such other duties as may be prescribed by the Board of Directors or President, under whose supervision he shall be. He shall keep in safe custody the seal of the Corporation and shall affix the same to any instrument requiring it.

6.9 Treasurer. (a) The Treasurer shall have custody of the corporate funds and securities and shall keep full and accurate accounts and records of receipts, disbursements and other transactions in books belonging to the Corporation, and shall deposit all moines and other valuable effects in the name and to the credit of the Corporation in such depositories as may be designated by the Board of Directors.

(b) The Treasurer shall disburse the funds of the Corporation as may be ordered by the Board of Directors, taking proper vouchers for such disbursements, and shall render the President and the Board of Directors, at its regular meetings, or when the President or Board of Directors so requires, an account of all his transactions as Treasurer and of the financial condition of the Corporation.

(c) If required by the Board of Directors, the Treasurer, as well as any other officers and employees, shall give the Corporation a bond of such type, character and amount as the Board of Directors may require.

6.10 Assistant Secretary and Assistant Treasurer. In the absence of the Secretary or Treasurer, an Assistant Secretary or Assistant Treasurer, respectively shall perform the duties of the Secretary or Treasurer. Assistant Treasurers may be required to give bond as in 6.9 (c). The Assistant Secretaries and Assistant Treasurers, in general shall have such powers and perform such duties as the Treasurer or Secretary, respectively, or the Board of Directors or President may prescribe.

ARTICLE 7
PROTECTION OF OFFICERS, DIRECTORS AND EMPLOYEES

7.1 Indemnification. The Corporation shall indemnify any Director or officer or former Director or officer of the Corporation, or any person who may have served at its request as a director or officer or former director or officer of another

corporation in which it owns shares of capital stock or of which it is a creditor, against expenses actually and necessarily incurred by him or her in connection with the defense of any action, suit, or proceeding, whether civil or criminal, in which he or she is made a party by reason of being or having been such Director or officer, except in relation to matters to which he or she shall be adjudged in such action, suit or proceeding to be liable for intentional misconduct or a knowing violation of law in the performance of duty. The Corporation shall also reimburse any such Director or officer or former Director or officer or any such person serving or formerly serving in the capacities set forth in the first sentence above at the request of the Corporation for the reasonable cost of settlement of any such action, suit or proceeding, if it shall be found by a majority of the Directors not involved in the matter of controversy, whether or not a quorum, or by written recommendation of legal counsel to the Corporation that it was in the best interest of the Corporation that such settlement be made, and that such Director or officer or former Director or officer or such person was not guilty of willful misconduct or a knowing violation of law in the performance of duty.

7.2 Expenses Advanced. The Corporation may pay in advance any expenses which may become subject to indemnification if the Board of Directors authorizes the specific payment, and the person receiving the payment undertakes in writing to repay unless it is ultimately determined that he is entitled to indemnification by the Corporation.

7.3 Insurance. The Corporation may purchase and maintain insurance on behalf of any person who is or was a Director, officer, employee or agent of the Corporation or is or was serving at the request of the Corporation as a director, officer, employee or agent of another corporation, partnership, joint venture, trust or other enterprise against any liability asserted against him and incurred by him in any such capacity or arising out of his status as such, whether or not the Corporation would have the power to indemnify him against such liability under these Bylaws or the laws of the State of Texas.

7.4 Other Protection and Indemnification. The protection and indemnification provided hereunder shall not be deemed exclusive of any other rights to which such Director or officer or former Director or officer or such person may be entitled, under any agreement, insurance policy or vote of members, or otherwise.

ARTICLE 8
GENERAL PROVISIONS

8.1 Fiscal Year. The fiscal year of the Corporation shall begin on the first day of January and end on the last day of December.

8.2 Seal. The Board of Directors shall provide a corporate seal which shall be in the form of a circle and shall have inscribed thereon the name of the corporation, the words "District of Columbia" and the year "1983". The seal may be used by causing it or a facsimile thereof to be impressed or affixed or in any manner reproduced.

8.3 Minutes. The Corporation shall keep correct and complete books and records of account and shall keep minutes of the proceedings of its members and Board of Directors, and shall keep at its registered office or principal place of business, a record of its members, giving the names and addresses of all members.

8.4 Amendment. These bylaws may be altered, amended or repealed and new bylaws may be adopted by the Board of Directors, subject to repeal or change by action of the members, at any meeting of the Board of Directors at which a

quorum is present, provided notice of the proposed alteration, amendment, or repeal is contained in the notice of the meeting. In addition, members representing at least five percent (5%) of the total membership may, by initiative and referendum, propose amendments to these bylaws for adoption by the Board of Directors or by affirmative vote of two-thirds (2/3) majority of the then-existing voting members. At least thirty (30) days written notice of any meeting to consider adoption of an amendment proposed by membership initiative and referendum shall be provided to the Board of Directors or the membership.

8.5 Notice. Any notice to Directors or members shall be in writing and shall be delivered personally or mailed to the Directors or members at their respective addresses appearing on the books of the Corporation. Notice by mail shall be deemed to be given at the time when the same shall be deposited in the United States mail, postage prepaid. Notice to Directors may also be given by telegram. Whenever any notice is required to be given under the provisions of applicable statues or of the Articles of Incorporation or of these Bylaws, a waiver thereof in writing signed by the person or persons entitled to such notice, whether before or after the time stated therein, shall be deemed equivalent to the giving of such notice.

KNOW ALL MEN BY THESE PRESENTS, that I, the undersigned, being the Executive Director of **UNITED SERVICE ASSOCIATION FOR HEALTH CARE**, do hereby certify that the above and foregoing Bylaws, consisting of Eight (8) Articles, were duly adopted as the Bylaws of this Corporation, amending and superseding any bylaws previously adopted by the Corporation, and that the same do now constitute the Bylaws of said Corporation.

DATED this the 10th day of June , 1994.

DR. SARA EARNEST, Executive Director

A STOCK COMPANY
LINCOLN, NEBRASKA

GROUP DENTAL AND EYE CARE INSURANCE POLICY

The Policyholder	**UNITED SERVICE ASSOCIATION FOR HEALTHCARE**		
		Policy Number	**10-350300**
State of Delivery	**District of Columbia**	**Plan Effective Date**	**July 1, 2002**
		Plan Change Effective Date - Dental	**September 1, 2005**
Premium Due Date 1st of each month.		**Renewal Date**	**July 1, 2007**

Ameritas Life Insurance Corp. agrees to pay, with respect to each Insured Person, the group insurance benefits provided in this policy.

This policy is issued to the Policyholder in consideration of the Policyholder's application and the payment of premiums, as provided herein.

This policy is delivered in and governed by the laws of the state of delivery.

AMERITAS LIFE INSURANCE CORP.

Jan M. Connolly
Secretary

JoAnn M Martin
President

Notice of Grievance Procedures

In accordance with Chapter 60 of Title 22
of the District of Columbia Municipal Regulations
Health Benefits Plan Members Bill of Rights

Quality Control Unit
P.O. Box 82657
Lincoln, NE 68501-2657
800-366-5933

Please read this notice carefully. This notice contains important information about how to file grievances with your insurer. You also have the right to ask your insurer to assist you in filing a grievance, review its decisions involving your requests for service, or your requests to have your claims paid.

I. Definitions

"Adverse Determination" means a determination by an insurer that an admission, availability of care, continued stay, or other health care service is or is not a covered benefit; and if it is a covered benefit, that it has been reviewed and does not meet the insurer's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness, and the requested health care service is therefore denied, reduced, limited, delayed or terminated.

"Grievance" means a written request by a member or member representative for review of a decision of an insurer to deny, reduce, limit, terminate or delay covered health care services to a member.

II. Levels of Review

The following levels of review will be available to a member:

Informal Internal Review

Formal Internal Review - following Informal Internal Review if grievance is not resolved

External Review - following a two-level internal review, the member has a right to request an external review. Request must be made within 30 days following receipt of an adverse formal internal review grievance decision.

A. Informal Internal Review

Any member dissatisfied with an adverse decision shall be provided an opportunity to discuss and review the decision with the insurer's quality control unit. The member has a right to designate a member representative to participate in the grievance process. A written decision to the member will be provided within 14 working days after the request for the informal internal review has been filed. The written explanation of a grievance decision following the informal internal review will also include notice to the member of their right to request a formal internal review.

B. Formal Internal Review

A member or member representative dissatisfied with the grievance decision rendered in the informal internal review process may seek a formal internal review before a reviewer or a panel of health care professionals selected by the insurer based upon the specific issues presented by the grievance.

Each request for a formal internal review shall be acknowledged by the insurer in writing, to the

member or member representative within 10 business days of receipt. If the insurer has determined that there is insufficient information to complete the formal review, the insurer shall notify the member that it cannot proceed with the grievance review without additional information, specifying what additional information is required and that the insurer will assist the member in gathering the necessary information without further delay.

The reviewer or panel selected shall not have been involved in the grievance decision under review. In all reviews requiring medical expertise, the reviewer or panel shall include at least one medical reviewer trained and certified, by a recognized specialty board in the same specialty as the matter at issue. Each medical reviewer shall be a health care provider possessing a nonrestricted license to practice and have no history of disciplinary action or sanctions pending or taken against them by any governmental or professional regulatory body.

Each formal internal review shall be concluded as soon as possible after receipt of all necessary documentation by the insurer, but in no event later than 30 business days after the insurer has received notice of the request for a formal internal review.

C. External Review

The member has a right to request an external review after exhausting the insurer's internal grievance process. The member has 30 business days after the receipt of an adverse formal internal review decision to file a request for an external review with the Director of the Department of Health. The member also has a right to request external review if a grievance decision has not been rendered within 30 business days after the filing of a grievance.

D. Written Decision

When a decision is issued from any level of review, the following information will be included in the written decision:

1. a statement of the reviewer's understanding of the grievance;
2. the decision stated in clear terms and the contract basis or medical rationale supporting the decision, a reference to the evidence or documentation used as a basis for the decision; and
3. a description of the process to request the next level of reviews, as applicable. These instructions will include telephone numbers and titles of persons to contact and the applicable time frames. These instructions will be in at least 12-point typeface.

E. Getting Assistance

You may contact us by submitting a request for review to:

Attn: Quality Control Unit
P.O. Box 82657
Lincoln, NE 68501-2657
800-366-5933
FAX: 402-390-2580

If you are dissatisfied with the resolution reached through the insurer's internal grievance system as defined above, then you may contact the Department of Insurance, Securities and Banking at the following:

Consumer Services Division
Department of Insurance, Securities and Banking
810 First Street, NE, Suite 701

Washington, D.C. 20002
202-727-8000

If you are dissatisfied with the resolution reached through the insurer's internal grievance system regarding medical necessity as defined above, then you may contact the Director of the Department of Health at the following:

Grievance and Appeals Coordinator
District of Columbia Department of Health
825 N.E. Capital Street, 4th Floor
Washington, D.C. 20002
202-442-5977 or 202-442-5979

DISTRICT OF COLUMBIA
LIFE & HEALTH INSURANCE GUARANTY
ASSOCIATION ACT OF 1992

SUMMARY OF GENERAL PURPOSES AND
CURRENT LIMITATIONS OF COVERAGE

Residents of the District of Columbia who purchase health insurance, life insurance, and annuities should know that the insurance companies licensed in the District of Columbia to write these types of insurance are members of the District of Columbia Life and Health Insurance Guaranty Association. The purpose of this Guaranty Association is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the Guaranty Association will assess its other member insurance companies for the money to pay the claims of insured persons who live in the District of Columbia and, in some cases, to keep coverage in force. The valuable extra protection provided by these insurers through the Guaranty Association is not unlimited, however, as noted on the other side of this page.

DISTRICT OF COLUMBIA
LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION

DISCLAIMER

The District of Columbia Life and Health Insurance Guaranty Association provides coverage of claims under some type of policies if the insurer becomes impaired or insolvent. **COVERAGE MAY NOT BE AVAILABLE FOR YOUR POLICY.** *Even if coverage is provided, there are significant limits and exclusions. Coverage is generally conditioned on residence in the District of Columbia. Other conditions may also preclude coverage.*

The District of Columbia Life and Health Insurance Guaranty Association or the District of Columbia Superintendent of Insurance will respond to any questions you may have which are not answered by this document. Your insurer and agent are prohibited by law from using the existence of the association or its coverage to sell you an insurance policy.

You should not rely on availability of coverage under the Life and Health Insurance Guaranty Association Act of 1992 when selecting an insurer.

Policyholders with additional questions may contact:

Mr. Robert M. Willis
Executive Director
District of Columbia Life and Health
Insurance Guaranty Association
1290 G Street, N.W.
Suite 800
Washington, D.C. 20005
(202) 434-8771
Fax: (202) 347-2990

Mr. Lawrence H. Mirel
Commissioner
District of Columbia Department of
Insurance and Securities Regulation
Insurance Administration
810 First Street, N.E., Suite 701
Washington, D.C. 20002
(202) 727-8000
Fax: (202) 535-1196

The District of Columbia law that provides for this safety net coverage is called the Life and Health Insurance Guaranty Association Act of 1992. The other side of this page contains a brief summary of this law's coverages, exclusions and limits. This summary does not cover all provisions of the law; nor does it in any way change anyone's rights or obligations under the act or the rights or obligations of the Guaranty Association. If you have obtained this document from an agent in connection with the purchase of a policy, you should be aware that its delivery to you does not guarantee that your policy is covered by the Guaranty Association.

(Please turn to other side)

COVERAGE

Generally, individuals will be protected by the District of Columbia Life and Health Insurance Guaranty Association if they live in the District of Columbia and are insured under a health insurance, life insurance, or annuity contract issued by a member insurer, or if they are insured under a group insurance contract issued by a member insurer. The beneficiaries, payees or assignees of insured persons are protected as well, even if they live in another state.

EXCLUSIONS FROM COVERAGE

However, persons holding such policies are not protected by this Guaranty Association if:

* they are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state of incorporation);

* their insurer was not authorized to do business in the District of Columbia; or

* their policy was issued by a charitable organization, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company, an insurance exchange, a non profit hospital service organization, a health maintenance organization, or a risk retention group.

The Guaranty Association also does not provide coverage for:

* any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk;

* any policy of reinsurance (unless an assumption certificate was issued);

* any plan or program of an employer or association that provides life, health, or annuity benefits to its employees or members to the extent the plan is self funded or uninsured;

* interest rate guarantees which exceed certain statutory limitations;

* dividends, experience rating credits, or fees for services in connection with a policy;

* credits given in connection with the administration of a policy by a group contract holder; or for

* unallocated annuity contracts.

LIMITS ON AMOUNT OF COVERAGE

The Act also limits the amount the Guaranty Association is obligated to pay. The benefits for which the Guaranty Association may become liable shall be limited to the lesser of either the contractual obligations for which the insurer is liable or for which the insurer would have been liable if it were not an impaired or insolvent insurer, or with respect to any one life, regardless of the number of policies, contracts, or certificates, in the case of life insurance, $300,000 in death benefits but not more than $100,000 in net cash surrender or withdrawal values; in the case of health insurance, $100,000 in health insurance benefits; and, with respect to annuities, $300,000 in the present value of annuity benefits. Finally, in no event is the Guaranty Association liable for more than $300,000 with respect to any one individual.

TABLE OF CONTENTS

SCHEDULE OF BENEFITS
OUTLINE OF COVERAGE

The Insurance for each Insured and each Insured Dependent will be based on the Insured's class shown in this Schedule of Benefits.

Benefit Class	Class Description
Class 1	All Eligible Members
Class 2	All Eligible Members
Class 3	All Eligible Members
Class 4	All Eligible Members

Class Number 1

DENTAL EXPENSE BENEFITS

When you select a Participating Provider, a discounted fee schedule is used which is intended to provide you, the Insured, reduced out of pocket costs.

Deductible Amount:

Type 1 Procedures - Each Benefit Period	$50
Combined Type 2 and Type 3 Procedures - Each Benefit Period	$100

On the date that the members of one family have satisfied the Maximum Family Deductible shown below, no covered Expenses incurred after that date by any other family member will be applied toward the satisfaction of any Deductible Amount for the rest of that Benefit Period.

Maximum Family Deductible	$ 300

Coinsurance Percentage:	
Type 1 Procedures	100% of Schedule
Type 2 Procedures	100% of Schedule
Type 3 Procedures	100% of Schedule

Maximum Amount - Each Benefit Period	$1,000

You and/or your dependents must be insured under the dental plan for 24 months to be eligible for Type 3 Procedures. Please refer to the DENTAL EXPENSE BENEFITS page for details regarding elimination period(s), limitations and exclusions.

EYE CARE EXPENSE BENEFITS

When you select a Participating Provider, a discounted fee schedule is used which is intended to provide you, the Insured, reduced out of pocket costs.

Deductible Amount	$0

Please refer to the EYE CARE EXPENSE BENEFITS page for details regarding frequency, limitations, and exclusions.

Class Number 2

EYE CARE EXPENSE BENEFITS

When you select a Participating Provider, a discounted fee schedule is used which is intended to provide you, the Insured, reduced out of pocket costs.

Deductible Amount	$0

Please refer to the EYE CARE EXPENSE BENEFITS page for details regarding frequency, limitations, and exclusions.

Class Number 3

DENTAL EXPENSE BENEFITS

When you select a Participating Provider, a discounted fee schedule is used which is intended to provide you, the Insured, reduced out of pocket costs.

Deductible Amount:

Type 1 Procedures - Each Benefit Period	$50
Combined Type 2 and Type 3 Procedures - Each Benefit Period	$100

On the date that the members of one family have satisfied the Maximum Family Deductible shown below, no covered Expenses incurred after that date by any other family member will be applied toward the satisfaction of any Deductible Amount for the rest of that Benefit Period.

Maximum Family Deductible	$ 300

Coinsurance Percentage:	
Type 1 Procedures	100% of Schedule
Type 2 Procedures	100% of Schedule
Type 3 Procedures	100% of Schedule

Maximum Amount - Each Benefit Period	$1,000

You and/or your dependents must be insured under the dental plan for 12 months to be eligible for Type 3 Procedures. Please refer to the DENTAL EXPENSE BENEFITS page for details regarding elimination period(s), limitations and exclusions.

EYE CARE EXPENSE BENEFITS

When you select a Participating Provider, a discounted fee schedule is used which is intended to provide you, the Insured, reduced out of pocket costs.

Deductible Amount	$0

Please refer to the EYE CARE EXPENSE BENEFITS page for details regarding frequency, limitations, and exclusions.

Class Number 4

DENTAL EXPENSE BENEFITS

When you select a Participating Provider, a discounted fee schedule is used which is intended to provide you, the Insured, reduced out of pocket costs.

Deductible Amount:

Type 1 Procedures	$0
Type 2 Procedures - Each Benefit Period	$50

Coinsurance Percentage:

Type 1 Procedures	100% of Schedule
Type 2 Procedures	100% of Schedule

Maximum Amount - Each Benefit Period	$1,000

EYE CARE EXPENSE BENEFITS

When you select a Participating Provider, a discounted fee schedule is used which is intended to provide you, the Insured, reduced out of pocket costs.

Deductible Amount	$0

Please refer to the EYE CARE EXPENSE BENEFITS page for details regarding frequency, limitations, and exclusions.

Class Number 1

INCREASED DENTAL MAXIMUM BENEFIT

Carry Over Amount Per Insured Person – Each Benefit Period	$250
Benefit Threshold Per Insured Person – Each Benefit Period	$500
Maximum Carry Over Amount	$1,000

After the first Benefit Period following the coverage effective date, the Maximum Amount for Dental Expenses Per Insured Person as shown in the Schedule of Benefits may be increased by the Carry Over Amount if:

a) The Insured Person has submitted a claim for dental expenses incurred during the preceding Benefit Period; and

b) The benefits paid for dental expenses incurred in the preceding Benefit Period did not exceed the Benefit Threshold.

In each succeeding Benefit Period in which the total dental expense benefits paid do not exceed the Benefit Threshold, the Insured Person will be eligible for the Carry Over Amount.

The Carry Over Amount can be accumulated from one Benefit Period to the next up to the Maximum Carry Over amount unless:

a) During any Benefit Period, dental expense benefits are paid in excess of the Threshold. In this instance, there will be no additional Carry Over Amount for that Benefit Period; or

b) During any Benefit Period, no claims for dental expenses incurred during the preceding Benefit Period are submitted. In this instance, there will be no Carry Over Amount for that Benefit Period, and any accumulated Carry Over Amounts from previous Benefit Periods will be forfeited.

Eligibility for the Carry Over Amount will be established or reestablished at the time the first claim in a Benefit Period is received for dental expenses incurred during that Benefit Period.

In order to properly calculate the Carry Over Amount, claims should be submitted timely in accordance with the Proof of Loss provision found within the General Provisions. You have the right to request review of prior Carry Over Amount calculations. The request for review must be within 24 months from the date the Carry Over Amount was established.

Class Number 3

INCREASED DENTAL MAXIMUM BENEFIT

Carry Over Amount Per Insured Person – Each Benefit Period	$250
Benefit Threshold Per Insured Person – Each Benefit Period	$500
Maximum Carry Over Amount	$1,000

After the first Benefit Period following the coverage effective date, the Maximum Amount for Dental Expenses Per Insured Person as shown in the Schedule of Benefits may be increased by the Carry Over Amount if:

a) The Insured Person has submitted a claim for dental expenses incurred during the preceding Benefit Period; and

b) The benefits paid for dental expenses incurred in the preceding Benefit Period did not exceed the Benefit Threshold.

In each succeeding Benefit Period in which the total dental expense benefits paid do not exceed the Benefit Threshold, the Insured Person will be eligible for the Carry Over Amount.

The Carry Over Amount can be accumulated from one Benefit Period to the next up to the Maximum Carry Over amount unless:

a) During any Benefit Period, dental expense benefits are paid in excess of the Threshold. In this instance, there will be no additional Carry Over Amount for that Benefit Period; or

b) During any Benefit Period, no claims for dental expenses incurred during the preceding Benefit Period are submitted. In this instance, there will be no Carry Over Amount for that Benefit Period, and any accumulated Carry Over Amounts from previous Benefit Periods will be forfeited.

Eligibility for the Carry Over Amount will be established or reestablished at the time the first claim in a Benefit Period is received for dental expenses incurred during that Benefit Period.

In order to properly calculate the Carry Over Amount, claims should be submitted timely in accordance with the Proof of Loss provision found within the General Provisions. You have the right to request review of prior Carry Over Amount calculations. The request for review must be within 24 months from the date the Carry Over Amount was established.

PREMIUMS

TABLE OF MONTHLY PREMIUM RATES

Classes 01,03	
Dental Care Insurance	$9.78 per Insured Person and/or Dependent(s)
Class 4	
Dental Care Insurance	$4.76 per Insured Person and/or Dependent(s)
Classes 01,03,04	
Eye Care Insurance	$2.24 per Insured Person and/or Dependent(s)
Class 2	
Eye Care Insurance	$2.60 per Insured Person and/or Dependent(s)

PAYMENT OF PREMIUMS. The first premium will be due on the Policy Effective Date to cover the period from that date to the first Premium Due Date. Other premiums will be due on or before each Premium Due Date. Premiums are payable at our Home Office or at some other location to which we and the Policyholder agree.

PREMIUM DUE DATE. The Premium Due Date will be the first day of the month that falls on or after the Policy Effective Date. If we agree with the Policyholder to the payment of premiums on a basis other than monthly, the Premium Due Date will be fixed to match the correct basis. If there is a change in the method of payment or Premium Due Date, a pro-rata charge in the premium due will be made.

PREMIUM STATEMENTS. The premium due as of any Premium Due Date is the number of units in force on such date for each type of insurance multiplied by the rate shown in the Table of Premium Rates. A premium statement will be made as of the Premium Due Date showing the premium payable. If premiums are payable on other than a monthly basis, each statement will show any pro-rata premium charges and credits in the last premium period due to changes in the number of Insureds and in the amount of insurance for which people are insured. This is subject to the rules below.

SIMPLIFIED ACCOUNTING. The premium will start on the Premium Due Date falling on or after the date the insurance or the increase in the insurance is effective for: a) a person becoming insured; or b) an increase in the amount of insurance on any person. The premium will stop on the Premium Due Date falling on or after the date of termination of insurance or through the date of service of the last paid claim. There will be no pro-rata charges or credits for a partial month. If premiums are payable other than monthly, charges and credits will be figured as though the Premium Due Date is monthly.

We will be liable for the return of unearned premiums to the Policyholder only for the 3 months before the date we receive evidence that a return is due.

ADJUSTMENTS IN PREMIUM RATES. We may change the rates shown in the Table of Premium Rates by giving the Policyholder at least 30 days advance written notice. We may change the rates at any time the Schedule of Benefits, or any other terms and conditions of the policy, are changed. We will not change the rates until the Renewal Date shown on the policy cover or more than once in any 21 month period thereafter, unless there is a change in the Schedule of Benefits or a change in any other terms and conditions in the policy.

Notwithstanding the above, the Company reserves the right to change any one or more of the rates prior to the Renewal Date or more than once in any 21 month period thereafter upon the occurrence of one or both of the following:

1. We determine that the average number of dependent children for each Insured with Dependent coverage exceeds 4.0; and/or

2. We determine that the number of Insureds is less than 80% of the number of Insureds covered under the Policy as of either (i) the Plan Effective Date, if during the period of time between the Plan Effective Date and the Renewal Date, or (ii) the most recent 21 month anniversary of the Renewal Date.

Should either or both of the above occur and should we elect to change rates as a result, we agree to notify the Policyholder of the corresponding rate changes at least 30 days in advance of the Premium Due Date for which the rate change shall be effective. The right to change rates as well as the timing of such changes in the above two limited situations shall at all times be subject to applicable state laws and regulations.

RENEWAL DATE refers to the date each calendar year that the coverage issued under the group policy is considered for renewal. The Renewal Date(s) are shown on the policy cover.

DEFINITIONS

COMPANY refers to Ameritas Life Insurance Corp. The words "we", "us" and "our" refer to Company. Our Home Office address is 5900 "O" Street, Lincoln, Nebraska 68510.

POLICYHOLDER refers to the Policyholder stated on the face page of the policy.

INSURED refers to a person:

a. who is a Member of the eligible class; and

b. who has qualified for insurance by completing the eligibility period, if any; and

c. for whom the insurance has become effective.

CHILD. Child refers to the child of the Insured or a child of the Insured's spouse, if they otherwise meet the definition of Dependent.

Class Number 1

DEPENDENT refers to:

a. an Insured's spouse.

b. each unmarried child less than 19 years of age, for whom the Insured or the insured's spouse, is legally responsible, including:

   i. natural born children;

   ii. adopted children, eligible from the date of placement for adoption;

   iii. children covered under a Qualified Medical Child Support Order as defined by applicable Federal and State laws.

c. each unmarried child age 19 but less than 24 who is:

   i. a full time student at an accredited school or college, which includes a vocational, technical, vocational-technical, trade school or institute; and

   ii. primarily dependent on the Insured, the Insured's spouse for support and maintenance.

d. each unmarried child age 19 or older who:

   i. is Totally Disabled as defined below; and

   ii. becomes Totally Disabled while insured as a dependent under b. or c. above.

   Coverage of such child will not cease if proof of dependency and disability is given within 31 days of attaining the limiting age and subsequently as may be required by us but not more frequently than annually after the initial two-year period following the child's attaining the limiting age. Any costs for providing continuing proof will be at our expense.

Class Number 2

DEPENDENT refers to:

a. an Insured's spouse.

b. each unmarried child less than 19 years of age, for whom the Insured or the insured's spouse, is legally responsible, including:

   i. natural born children;

   ii. adopted children, eligible from the date of placement for adoption;

   iii. children covered under a Qualified Medical Child Support Order as defined by applicable Federal and State laws.

c. each unmarried child age 19 but less than 24 who is:

   i. a full time student at an accredited school or college, which includes a vocational, technical, vocational-technical, trade school or institute; and

   ii. primarily dependent on the Insured, the Insured's spouse for support and maintenance.

d. each unmarried child age 19 or older who:

   i. is Totally Disabled as defined below; and

   ii. becomes Totally Disabled while insured as a dependent under b. or c. above.

   Coverage of such child will not cease if proof of dependency and disability is given within 31 days of attaining the limiting age and subsequently as may be required by us but not more frequently than annually after the initial two-year period following the child's attaining the limiting age. Any costs for providing continuing proof will be at our expense.

Class Number 3

DEPENDENT refers to:

a. an Insured's spouse.

b. each unmarried child less than 19 years of age, for whom the Insured or the insured's spouse, is legally responsible, including:

   i. natural born children;

   ii. adopted children, eligible from the date of placement for adoption;

   iii. children covered under a Qualified Medical Child Support Order as defined by applicable Federal and State laws.

c. each unmarried child age 19 but less than 24 who is:

   i. a full time student at an accredited school or college, which includes a vocational, technical, vocational-technical, trade school or institute; and

ii. primarily dependent on the Insured, the Insured's spouse for support and maintenance.

d. each unmarried child age 19 or older who:

i. is Totally Disabled as defined below; and

ii. becomes Totally Disabled while insured as a dependent under b. or c. above.

Coverage of such child will not cease if proof of dependency and disability is given within 31 days of attaining the limiting age and subsequently as may be required by us but not more frequently than annually after the initial two-year period following the child's attaining the limiting age. Any costs for providing continuing proof will be at our expense.

Class Number 4

DEPENDENT refers to:

a. an Insured's spouse.

b. each unmarried child less than 19 years of age, for whom the Insured or the insured's spouse, is legally responsible, including:

i. natural born children;

ii. adopted children, eligible from the date of placement for adoption;

iii. children covered under a Qualified Medical Child Support Order as defined by applicable Federal and State laws.

c. each unmarried child age 19 but less than 24 who is:

i. a full time student at an accredited school or college, which includes a vocational, technical, vocational-technical, trade school or institute; and

ii. primarily dependent on the Insured, the Insured's spouse for support and maintenance.

d. each unmarried child age 19 or older who:

i. is Totally Disabled as defined below; and

ii. becomes Totally Disabled while insured as a dependent under b. or c. above.

Coverage of such child will not cease if proof of dependency and disability is given within 31 days of attaining the limiting age and subsequently as may be required by us but not more frequently than annually after the initial two-year period following the child's attaining the limiting age. Any costs for providing continuing proof will be at our expense.

All Classes

TOTAL DISABILITY describes the Insured's Dependent as:

1. Continuously incapable of self-sustaining employment because of mental retardation or physical handicap; and

2. Chiefly dependent upon the Insured for support and maintenance.

DEPENDENT UNIT refers to all of the people who are insured as the dependents of any one Insured.

PROVIDER refers to any person who is licensed by the law of the state in which treatment is provided within the scope of the license.

Class Number 1

LATE ENTRANT refers to any person:

a. whose Effective Date of insurance is more than 31 days from the date the person becomes eligible for insurance; or

b. who has elected to become insured again after canceling a premium contribution agreement.

Class Number 3

LATE ENTRANT refers to any person:

a. whose Effective Date of insurance is more than 31 days from the date the person becomes eligible for insurance; or

b. who has elected to become insured again after canceling a premium contribution agreement.

Class Number 4

LATE ENTRANT refers to any person:

a. whose Effective Date of insurance is more than 31 days from the date the person becomes eligible for insurance; or

b. who has elected to become insured again after canceling a premium contribution agreement.

All Classes

PLAN EFFECTIVE DATE refers to the date coverage under the policy becomes effective. The Plan Effective Date for the Policyholder is shown on the policy cover. The effective date of coverage for an Insured is shown in the Policyholder's records.

All insurance will begin at 12:01 A.M. on the Effective Date. It will end after 11:59 P.M. on the Termination Date. All times are stated as Standard Time of the residence of the Insured.

PLAN CHANGE EFFECTIVE DATE refers to the date that the policy provisions originally issued to the Policyholder change as requested by the Policyholder. The Plan Change Effective date for the Policyholder will be shown on the policy cover, if the Policyholder has requested a change. The plan change effective date for an Insured is shown in the Policyholder’s records or on the cover of the certificate.

CONDITIONS FOR INSURANCE COVERAGE
ELIGIBILITY

ELIGIBLE CLASS FOR MEMBERS. The members of the eligible class(es) are shown on the Schedule of Benefits. Each member of the eligible class (referred to as "Member") will qualify for such insurance on the day he or she completes the required eligibility period, if any. Members choosing to elect coverage will hereinafter be referred to as "Insured."

Class Number 1

A member of the Eligible Class for Personal Insurance is any eligible member of the Association participating in the overall benefits package.

If a husband and wife are both Members and if either of them insures their dependent children, then the husband or wife, whoever elects, will be considered the dependent of the other. As a dependent, the person will not be considered a Member of the Eligible Class, but will be eligible for insurance as a dependent.

ELIGIBLE CLASS FOR DEPENDENT INSURANCE. Each Member of the eligible class(es) for dependent coverage is eligible for the Dependent Insurance under the policy and will qualify for this Dependent Insurance on the first of the month falling on or next following the latest of:

1. the day he or she qualifies for coverage as a Member;

2. the day he or she first becomes a Member; or

3. the day he or she first has a dependent. For dependent children, a newborn child will be considered an eligible dependent upon reaching their 2nd birthday. The child may be added at birth or within 31 days of the 2nd birthday.

A Member must be an Insured to also insure his or her dependents.

A member of the Eligible Class for Dependent Insurance is any eligible member of the Association participating in the overall benefits package.

Any husband or wife who elects to be a dependent rather than a member of the Eligible Class for Personal Insurance, as explained above, is not a member of the Eligible Class for Dependent Insurance.

When a member of the Eligible Class for Dependent Insurance dies and, if at the date of death, has dependents insured, the Policyholder has the option of offering the dependents of the deceased member continued coverage. If elected by the Policyholder and the affected dependents, the name of such deceased member will continue to be listed as a member of the Eligible Class for Dependent Insurance.

CONTRIBUTION REQUIREMENTS. Member Insurance: An Insured may or may not be required to contribute to the payment of his or her insurance premiums.

Dependent Insurance: An Insured may or may not be required to contribute to the payment of insurance premiums for his or her dependents.

ELIGIBILITY PERIOD. For Members on the Plan Effective Date of the policy, qualification will occur on the first of the month falling on or first following the date of membership.

For persons who become Members after the Plan Effective Date of the policy, qualification will occur on the first of the month falling on or first following the date of membership.

If employment is the basis for membership in the Eligible Class for Members, an Insured whose eligibility terminates and is established again, may or may not have to complete a new eligibility period before he or she can again qualify for insurance.

ELIMINATION PERIOD. Certain covered expenses may be subject to an elimination period, please refer to the TABLE OF DENTAL PROCEDURES, DENTAL EXPENSE BENEFITS, and if applicable, the ORTHODONTIC EXPENSE BENEFITS pages for details.

EFFECTIVE DATE. Each Member has the option of being insured and insuring his or her Dependents. To elect coverage, he or she must agree in writing to contribute to the payment of the insurance premiums. The Effective Date for each Member and his or her Dependents, will be the first of the month falling on or next following:

1. the date on which the Member qualifies for insurance, if the Member agrees to contribute on or before that date.

2. the date on which the Member agrees to contribute, if that date is within 31 days after the date he or she qualifies for insurance.

3. the date we accept the Member and/or Dependent for insurance when the Member and/or Dependent is a Late Entrant. The Member and/or Dependent will be subject to any limitation concerning Late Entrants.

Class Number 2

A member of the Eligible Class for Personal Insurance is any eligible member of the Association participating in the overall benefits package.

If a husband and wife are both Members and if either of them insures their dependent children, then the husband or wife, whoever elects, will be considered the dependent of the other. As a dependent, the person will not be considered a Member of the Eligible Class, but will be eligible for insurance as a dependent.

ELIGIBLE CLASS FOR DEPENDENT INSURANCE. Each Member of the eligible class(es) for dependent coverage is eligible for the Dependent Insurance under the policy and will qualify for this Dependent Insurance on the first of the month falling on or next following the latest of:

1. the day he or she qualifies for coverage as a Member;

2. the day he or she first becomes a Member; or

3. the day he or she first has a dependent. For dependent children, a newborn child will be considered an eligible dependent upon reaching their 2nd birthday. The child may be added at birth or within 31 days of the 2nd birthday.

A Member must be an Insured to also insure his or her dependents.

A member of the Eligible Class for Dependent Insurance is any eligible member of the Association participating in the overall benefits package.

Any husband or wife who elects to be a dependent rather than a member of the Eligible Class for Personal Insurance, as explained above, is not a member of the Eligible Class for Dependent Insurance.

When a member of the Eligible Class for Dependent Insurance dies and, if at the date of death, has dependents insured, the Policyholder has the option of offering the dependents of the deceased member continued coverage.

If elected by the Policyholder and the affected dependents, the name of such deceased member will continue to be listed as a member of the Eligible Class for Dependent Insurance.

CONTRIBUTION REQUIREMENTS. Member Insurance: An Insured is required to contribute to the payment of his or her insurance premiums.

Dependent Insurance: An Insured is required to contribute to the payment of insurance premiums for his or her dependents.

ELIGIBILITY PERIOD. For Members on the Plan Effective Date of the policy, qualification will occur on the first of the month falling on or first following the date of membership.

For persons who become Members after the Plan Effective Date of the policy, qualification will occur on the first of the month falling on or first following the date of membership.

If employment is the basis for membership in the Eligible Class for Members, an Insured whose eligibility terminates and is established again, may or may not have to complete a new eligibility period before he or she can again qualify for insurance.

EFFECTIVE DATE. Each Member has the option of being insured and insuring his or her Dependents. To elect coverage, he or she must agree in writing to contribute to the payment of the insurance premiums. The Effective Date for each Member and his or her Dependents, will be the first of the month falling on or next following:

1. the date on which the Member qualifies for insurance, if the Member agrees to contribute on or before that date.

2. the date on which the Member agrees to contribute, if that date is within 31 days after the date he or she qualifies for insurance.

Class Number 3

A member of the Eligible Class for Personal Insurance is any eligible member of the Association participating in the overall benefits package.

If a husband and wife are both Members and if either of them insures their dependent children, then the husband or wife, whoever elects, will be considered the dependent of the other. As a dependent, the person will not be considered a Member of the Eligible Class, but will be eligible for insurance as a dependent.

ELIGIBLE CLASS FOR DEPENDENT INSURANCE. Each Member of the eligible class(es) for dependent coverage is eligible for the Dependent Insurance under the policy and will qualify for this Dependent Insurance on the first of the month falling on or next following the latest of:

1. the day he or she qualifies for coverage as a Member;

2. the day he or she first becomes a Member; or

3. the day he or she first has a dependent. For dependent children, a newborn child will be considered an eligible dependent upon reaching their 2nd birthday. The child may be added at birth or within 31 days of the 2nd birthday.

A Member must be an Insured to also insure his or her dependents.

A member of the Eligible Class for Dependent Insurance is any eligible member of the Association participating in the overall benefits package.

Any husband or wife who elects to be a dependent rather than a member of the Eligible Class for Personal Insurance, as explained above, is not a member of the Eligible Class for Dependent Insurance.

When a member of the Eligible Class for Dependent Insurance dies and, if at the date of death, has dependents insured, the Policyholder has the option of offering the dependents of the deceased member continued coverage. If elected by the Policyholder and the affected dependents, the name of such deceased member will continue to be listed as a member of the Eligible Class for Dependent Insurance.

CONTRIBUTION REQUIREMENTS. Member Insurance: An Insured may or may not be required to contribute to the payment of his or her insurance premiums.

Dependent Insurance: An Insured may or may not be required to contribute to the payment of insurance premiums for his or her dependents.

ELIGIBILITY PERIOD. For Members on the Plan Effective Date of the policy, qualification will occur on the first of the month falling on or first following the date of membership.

For persons who become Members after the Plan Effective Date of the policy, qualification will occur on the first of the month falling on or first following the date of membership.

If employment is the basis for membership in the Eligible Class for Members, an Insured whose eligibility terminates and is established again, may or may not have to complete a new eligibility period before he or she can again qualify for insurance.

ELIMINATION PERIOD. Certain covered expenses may be subject to an elimination period, please refer to the TABLE OF DENTAL PROCEDURES, DENTAL EXPENSE BENEFITS, and if applicable, the ORTHODONTIC EXPENSE BENEFITS pages for details.

EFFECTIVE DATE. Each Member has the option of being insured and insuring his or her Dependents. To elect coverage, he or she must agree in writing to contribute to the payment of the insurance premiums. The Effective Date for each Member and his or her Dependents, will be the first of the month falling on or next following:

1. the date on which the Member qualifies for insurance, if the Member agrees to contribute on or before that date.

2. the date on which the Member agrees to contribute, if that date is within 31 days after the date he or she qualifies for insurance.

3. the date we accept the Member and/or Dependent for insurance when the Member and/or Dependent is a Late Entrant. The Member and/or Dependent will be subject to any limitation concerning Late Entrants.

<u>Class Number 4</u>

A member of the Eligible Class for Personal Insurance is any eligible member of the Association participating in the overall benefits package.

If a husband and wife are both Members and if either of them insures their dependent children, then the husband or wife, whoever elects, will be considered the dependent of the other. As a dependent, the person will not be considered a Member of the Eligible Class, but will be eligible for insurance as a dependent.

ELIGIBLE CLASS FOR DEPENDENT INSURANCE. Each Member of the eligible class(es) for dependent coverage is eligible for the Dependent Insurance under the policy and will qualify for this Dependent Insurance on the first of the month falling on or next following the latest of:

1. the day he or she qualifies for coverage as a Member;

2. the day he or she first becomes a Member; or

3. the day he or she first has a dependent. For dependent children, a newborn child will be considered an eligible dependent upon reaching their 2nd birthday. The child may be added at birth or within 31 days of the 2nd birthday.

A Member must be an Insured to also insure his or her dependents.

A member of the Eligible Class for Dependent Insurance is any eligible member of the Association participating in the overall benefits package.

Any husband or wife who elects to be a dependent rather than a member of the Eligible Class for Personal Insurance, as explained above, is not a member of the Eligible Class for Dependent Insurance.

When a member of the Eligible Class for Dependent Insurance dies and, if at the date of death, has dependents insured, the Policyholder has the option of offering the dependents of the deceased member continued coverage. If elected by the Policyholder and the affected dependents, the name of such deceased member will continue to be listed as a member of the Eligible Class for Dependent Insurance.

CONTRIBUTION REQUIREMENTS. Member Insurance: An Insured may or may not be required to contribute to the payment of his or her insurance premiums.

Dependent Insurance: An Insured may or may not be required to contribute to the payment of insurance premiums for his or her dependents.

ELIGIBILITY PERIOD. For Members on the Plan Effective Date of the policy, qualification will occur on the first of the month falling on or first following the date of membership.

For persons who become Members after the Plan Effective Date of the policy, qualification will occur on the first of the month falling on or first following the date of membership.

If employment is the basis for membership in the Eligible Class for Members, an Insured whose eligibility terminates and is established again, may or may not have to complete a new eligibility period before he or she can again qualify for insurance.

ELIMINATION PERIOD. Certain covered expenses may be subject to an elimination period, please refer to the TABLE OF DENTAL PROCEDURES, DENTAL EXPENSE BENEFITS, and if applicable, the ORTHODONTIC EXPENSE BENEFITS pages for details.

EFFECTIVE DATE. Each Member has the option of being insured and insuring his or her Dependents. To elect coverage, he or she must agree in writing to contribute to the payment of the insurance premiums. The Effective Date for each Member and his or her Dependents, will be the first of the month falling on or next following:

1. the date on which the Member qualifies for insurance, if the Member agrees to contribute on or before that date.

2. the date on which the Member agrees to contribute, if that date is within 31 days after the date he or she qualifies for insurance.

3. the date we accept the Member and/or Dependent for insurance when the Member and/or Dependent is a Late Entrant. The Member and/or Dependent will be subject to any limitation concerning Late Entrants.

All Classes

EXCEPTIONS. If employment is the basis for membership, a Member must be in active service on the date the insurance, or any increase in insurance, is to take effect. If not, the insurance will not take effect until the day he or she returns to active service. Active service refers to the performance in the customary manner by an employee of all the regular duties of his or her employment with his or her employer on a full time basis at one of the employer's business establishments or at some location to which the employer's business requires the employee to travel.

A Member will be in active service on any regular non-working day if he or she is not totally disabled on that day and if he or she was in active service on the regular working day before that day.

If membership is by reason other than employment, a Member must not be totally disabled on the date the insurance, or any increase in insurance, is to take effect. The insurance will not take effect until the day after he or she ceases to be totally disabled.

TERMINATION DATES

Class Number 1

INSUREDS. The insurance for any Insured, will automatically terminate on the end of the month falling on or next following the **earliest of:**

1. the date the Insured ceases to be a Member;
2. the last day of the period for which the Insured has contributed, if required, to the payment of insurance premiums; or
3. the date the policy is terminated.

DEPENDENTS. The insurance for all of an Insured's dependents will automatically terminate on the end of the month falling on or next following the **earliest of:**

1. the date on which the Insured's coverage terminates;
2. the date on which the Insured ceases to be a Member;
3. the last day of the period for which the Insured has contributed, if required, to the payment of insurance premiums; or
4. the date all Dependent Insurance under the policy is terminated.

The insurance for any Dependent will automatically terminate on the end of the month falling on or next following the day before the date on which the dependent no longer meets the definition of a dependent. See "Definitions."

Class Number 2

INSUREDS. The insurance for any Insured, will automatically terminate on the end of the month falling on or next following the **earliest of:**

1. the date the Insured ceases to be a Member;
2. the last day of the period for which the Insured has contributed, if required, to the payment of insurance premiums; or
3. the date the policy is terminated.

DEPENDENTS. The insurance for all of an Insured's dependents will automatically terminate on the end of the month falling on or next following the **earliest of:**

1. the date on which the Insured's coverage terminates;
2. the date on which the Insured ceases to be a Member;
3. the last day of the period for which the Insured has contributed, if required, to the payment of insurance premiums; or
4. the date all Dependent Insurance under the policy is terminated.

The insurance for any Dependent will automatically terminate on the end of the month falling on or next following the day before the date on which the dependent no longer meets the definition of a dependent. See "Definitions."

Class Number 3

INSUREDS. The insurance for any Insured, will automatically terminate on the end of the month falling on or next following the **earliest of:**

1. the date the Insured ceases to be a Member;
2. the last day of the period for which the Insured has contributed, if required, to the payment of insurance premiums; or
3. the date the policy is terminated.

DEPENDENTS. The insurance for all of an Insured's dependents will automatically terminate on the end of the month falling on or next following the **earliest of:**

1. the date on which the Insured's coverage terminates;
2. the date on which the Insured ceases to be a Member;
3. the last day of the period for which the Insured has contributed, if required, to the payment of insurance premiums; or
4. the date all Dependent Insurance under the policy is terminated.

The insurance for any Dependent will automatically terminate on the end of the month falling on or next following the day before the date on which the dependent no longer meets the definition of a dependent. See "Definitions."

Class Number 4

INSUREDS. The insurance for any Insured, will automatically terminate on the end of the month falling on or next following the **earliest of:**

1. the date the Insured ceases to be a Member;
2. the last day of the period for which the Insured has contributed, if required, to the payment of insurance premiums; or
3. the date the policy is terminated.

DEPENDENTS. The insurance for all of an Insured's dependents will automatically terminate on the end of the month falling on or next following the **earliest of:**

1. the date on which the Insured's coverage terminates;
2. the date on which the Insured ceases to be a Member;
3. the last day of the period for which the Insured has contributed, if required, to the payment of insurance premiums; or
4. the date all Dependent Insurance under the policy is terminated.

The insurance for any Dependent will automatically terminate on the end of the month falling on or next following the day before the date on which the dependent no longer meets the definition of a dependent. See "Definitions."

All Classes

CONTINUATION OF COVERAGE. If coverage ceases according to TERMINATION DATE, some or all of the insurance coverages may be continued. Contact your plan administrator for details.

DENTAL EXPENSE BENEFITS

Class Number 1

We will determine dental expense benefits according to the terms of the group policy for dental expenses incurred by an Insured. An Insured person has the freedom of choice to receive treatment from any Provider.

PARTICIPATING AND NON-PARTICIPATING PROVIDERS. The Insured person may select a Participating Provider or a Non-Participating Provider. A Participating Provider agrees to provide services at a discounted fee to our Insureds. A Non-Participating Provider is any other Provider.

DETERMINING BENEFITS. The benefits payable will be determined by totaling all of the Covered Expenses submitted into each benefit type as shown in the Table of Dental Procedures. This amount is reduced by the Deductible, if any. The result is then multiplied by the Coinsurance Percentage(s) shown in the Schedule of Benefits. Benefits are subject to the Maximum Amount, if any, shown in the Schedule of Benefits.

BENEFIT PERIOD. Benefit Period refers to the period shown in the Table of Dental Procedures.

DEDUCTIBLE. The Deductible is shown on the Schedule of Benefits and is a specified amount of Covered Expenses that must be incurred and paid by each Insured person prior to any benefits being paid.

MAXIMUM AMOUNT. The Maximum Amount shown in the Schedule of Benefits is the maximum amount that may be paid for the Covered Expenses incurred by an Insured.

COVERED EXPENSES. Covered Expenses include:

1. only those expenses for dental procedures performed by a Provider; and
2. only those expenses for dental procedures listed and outlined on the Table of Dental Procedures.

Covered Expenses are subject to "Limitations." See Limitations and Table of Dental Procedures.

Benefits payable for Covered Expenses also will be limited to the lesser of:

1. the actual charge of the Provider.
2. the Maximum Covered Expense as determined by us.

MAC - The Maximum Allowable Charge is derived from the array of provider charges within a particular ZIP code area. These allowances are the charges accepted by general dentists who are Participating Providers. The MAC is reviewed and updated periodically to reflect increasing provider fees within the ZIP code area.

The Maximum Covered Expense is actually a scheduled dollar amount per procedure. The dollar amount for each procedure is listed within the Table of Dental Procedures. This dollar amount will not vary unless the policy is amended. At the time of amendment, a new Table of Dental Procedures will be provided to you for inclusion in your certificate of coverage.

ALTERNATIVE PROCEDURES. If two or more procedures are considered adequate and appropriate treatment to correct a certain condition under generally accepted standards of dental care, the amount of the Covered Expense will be equal to the charge for the least expensive procedure. This provision is NOT intended to dictate a course of treatment. Instead, this provision is designed to determine the amount of the plan allowance for a submitted treatment when an adequate and appropriate alternative procedure is available. Accordingly, you may choose to apply the alternate benefit amount determined under this provision toward payment of the submitted treatment.

We may request pre-operative dental x-ray films, periodontal charting and/or additional diagnostic data to determine the plan allowance for the procedures submitted. We strongly encourage pre-treatment estimates so you understand your benefits before any treatment begins. Ask your provider to submit a claim form for this purpose.

EXPENSES INCURRED. An expense is incurred at the time the impression is made for an appliance or change to an appliance. An expense is incurred at the time the tooth or teeth are prepared for a prosthetic crown, appliance, or fixed partial denture. For root canal therapy, an expense is incurred at the time the pulp chamber is opened. All other expenses are incurred at the time the service is rendered or a supply furnished.

LIMITATIONS. Covered Expenses will not include and benefits will not be payable for expenses incurred:

1. for Type 3 Procedures in the first 24 months the person is covered under this contract.

2. in the first 12 months that a person is insured if the person is a Late Entrant; except for evaluations, prophylaxis (cleanings), and fluoride application.

3. for initial placement of any prosthetic crown, appliance, or fixed partial denture unless such placement is needed because of the extraction of one or more teeth while the insured person is covered under this contract. But the extraction of a third molar (wisdom tooth) will not qualify under the above. Any such prosthetic crown, appliance, or fixed partial denture must include the replacement of the extracted tooth or teeth.

4. for appliances, restorations, or procedures to:

    a. alter vertical dimension;
    b. restore or maintain occlusion; or
    c. splint or replace tooth structure lost as a result of abrasion or attrition.

5. for any procedure begun after the insured person's insurance under this contract terminates; or for any prosthetic dental appliances installed or delivered more than 90 days after the Insured's insurance under this contract terminates.

6. to replace lost or stolen appliances.

7. for any treatment which is for cosmetic purposes.

8. for any procedure not shown in the Table of Dental Procedures. (There may be additional frequencies and limitations that apply, please see the Table of Dental Procedures for details.)

9. for orthodontic treatment under this benefit provision. (If orthodontic expense benefits have been included in this policy, please refer to the Schedule of Benefits and Orthodontic Expense Benefits provision found on 9260).

10. for which the Insured person is entitled to benefits under any workmen’s compensation or similar law, or charges for services or supplies received as a result of any dental condition caused or contributed to by an injury or sickness arising out of or in the course of any employment for wage or profit.

11. for charges which the Insured person is not liable or which would not have been made had no insurance been in force.

12. for services that are not required for necessary care and treatment or are not within the generally accepted parameters of care.

13. because of war or any act of war, declared or not.

Class Number 3

We will determine dental expense benefits according to the terms of the group policy for dental expenses incurred by an Insured. An Insured person has the freedom of choice to receive treatment from any Provider.

PARTICIPATING AND NON-PARTICIPATING PROVIDERS. The Insured person may select a Participating Provider or a Non-Participating Provider. A Participating Provider agrees to provide services at a discounted fee to our Insureds. A Non-Participating Provider is any other Provider.

DETERMINING BENEFITS. The benefits payable will be determined by totaling all of the Covered Expenses submitted into each benefit type as shown in the Table of Dental Procedures. This amount is reduced by the Deductible, if any. The result is then multiplied by the Coinsurance Percentage(s) shown in the Schedule of Benefits. Benefits are subject to the Maximum Amount, if any, shown in the Schedule of Benefits.

BENEFIT PERIOD. Benefit Period refers to the period shown in the Table of Dental Procedures.

DEDUCTIBLE. The Deductible is shown on the Schedule of Benefits and is a specified amount of Covered Expenses that must be incurred and paid by each Insured person prior to any benefits being paid.

MAXIMUM AMOUNT. The Maximum Amount shown in the Schedule of Benefits is the maximum amount that may be paid for the Covered Expenses incurred by an Insured.

COVERED EXPENSES. Covered Expenses include:

1. only those expenses for dental procedures performed by a Provider; and
2. only those expenses for dental procedures listed and outlined on the Table of Dental Procedures.

Covered Expenses are subject to "Limitations." See Limitations and Table of Dental Procedures.

Benefits payable for Covered Expenses also will be limited to the lesser of:

1. the actual charge of the Provider.
2. the Maximum Covered Expense as determined by us.

MAC - The Maximum Allowable Charge is derived from the array of provider charges within a particular ZIP code area. These allowances are the charges accepted by general dentists who are Participating Providers. The MAC is reviewed and updated periodically to reflect increasing provider fees within the ZIP code area.

The Maximum Covered Expense is actually a scheduled dollar amount per procedure. The dollar amount for each procedure is listed within the Table of Dental Procedures. This dollar amount will not vary unless the policy is amended. At the time of amendment, a new Table of Dental Procedures will be provided to you for inclusion in your certificate of coverage.

ALTERNATIVE PROCEDURES. If two or more procedures are considered adequate and appropriate treatment to correct a certain condition under generally accepted standards of dental care, the amount of the Covered Expense will be equal to the charge for the least expensive procedure. This provision is NOT intended to dictate a course of treatment. Instead, this provision is designed to determine the amount of the plan allowance for a submitted treatment when an adequate and appropriate alternative procedure is available. Accordingly, you may choose to apply the alternate benefit amount determined under this provision toward payment of the submitted treatment.

We may request pre-operative dental x-ray films, periodontal charting and/or additional diagnostic data to determine the plan allowance for the procedures submitted. We strongly encourage pre-treatment estimates so you understand your benefits before any treatment begins. Ask your provider to submit a claim form for this purpose.

EXPENSES INCURRED. An expense is incurred at the time the impression is made for an appliance or change to an appliance. An expense is incurred at the time the tooth or teeth are prepared for a prosthetic crown, appliance, or fixed partial denture. For root canal therapy, an expense is incurred at the time the pulp chamber is opened. All other expenses are incurred at the time the service is rendered or a supply furnished.

LIMITATIONS. Covered Expenses will not include and benefits will not be payable for expenses incurred:

1. for Type 3 Procedures in the first 12 months the person is covered under this contract.

2. in the first 12 months that a person is insured if the person is a Late Entrant; except for evaluations, prophylaxis (cleanings), and fluoride application.

3. for initial placement of any prosthetic crown, appliance, or fixed partial denture unless such placement is needed because of the extraction of one or more teeth while the insured person is covered under this contract. But the extraction of a third molar (wisdom tooth) will not qualify under the above. Any such prosthetic crown, appliance, or fixed partial denture must include the replacement of the extracted tooth or teeth.

4. for appliances, restorations, or procedures to:

    a. alter vertical dimension;
    b. restore or maintain occlusion; or
    c. splint or replace tooth structure lost as a result of abrasion or attrition.

5. for any procedure begun after the insured person's insurance under this contract terminates; or for any prosthetic dental appliances installed or delivered more than 90 days after the Insured's insurance under this contract terminates.

6. to replace lost or stolen appliances.

7. for any treatment which is for cosmetic purposes.

8. for any procedure not shown in the Table of Dental Procedures. (There may be additional frequencies and limitations that apply, please see the Table of Dental Procedures for details.)

9. for orthodontic treatment under this benefit provision. (If orthodontic expense benefits have been included in this policy, please refer to the Schedule of Benefits and Orthodontic Expense Benefits provision found on 9260).

10. for which the Insured person is entitled to benefits under any workmen’s compensation or similar law, or charges for services or supplies received as a result of any dental condition caused or contributed to by an injury or sickness arising out of or in the course of any employment for wage or profit.

11. for charges which the Insured person is not liable or which would not have been made had no insurance been in force.

12. for services that are not required for necessary care and treatment or are not within the generally accepted parameters of care.

13. because of war or any act of war, declared or not.

Class Number 4

We will determine dental expense benefits according to the terms of the group policy for dental expenses incurred by an Insured. An Insured person has the freedom of choice to receive treatment from any Provider.

PARTICIPATING AND NON-PARTICIPATING PROVIDERS. The Insured person may select a Participating Provider or a Non-Participating Provider. A Participating Provider agrees to provide services at a discounted fee to our Insureds. A Non-Participating Provider is any other Provider.

DETERMINING BENEFITS. The benefits payable will be determined by totaling all of the Covered Expenses submitted into each benefit type as shown in the Table of Dental Procedures. This amount is reduced by the Deductible, if any. The result is then multiplied by the Coinsurance Percentage(s) shown in the Schedule of Benefits. Benefits are subject to the Maximum Amount, if any, shown in the Schedule of Benefits.

BENEFIT PERIOD. Benefit Period refers to the period shown in the Table of Dental Procedures.

DEDUCTIBLE. The Deductible is shown on the Schedule of Benefits and is a specified amount of Covered Expenses that must be incurred and paid by each Insured person prior to any benefits being paid.

MAXIMUM AMOUNT. The Maximum Amount shown in the Schedule of Benefits is the maximum amount that may be paid for the Covered Expenses incurred by an Insured.

COVERED EXPENSES. Covered Expenses include:

1. only those expenses for dental procedures performed by a Provider; and
2. only those expenses for dental procedures listed and outlined on the Table of Dental Procedures.

Covered Expenses are subject to "Limitations." See Limitations and Table of Dental Procedures.

Benefits payable for Covered Expenses also will be limited to the lesser of:

1. the actual charge of the Provider.
2. the Maximum Covered Expense as determined by us.

MAC - The Maximum Allowable Charge is derived from the array of provider charges within a particular ZIP code area. These allowances are the charges accepted by general dentists who are Participating Providers. The MAC is reviewed and updated periodically to reflect increasing provider fees within the ZIP code area.

The Maximum Covered Expense is actually a scheduled dollar amount per procedure. The dollar amount for each procedure is listed within the Table of Dental Procedures. This dollar amount will not vary unless the policy is amended. At the time of amendment, a new Table of Dental Procedures will be provided to you for inclusion in your certificate of coverage.

ALTERNATIVE PROCEDURES. If two or more procedures are considered adequate and appropriate treatment to correct a certain condition under generally accepted standards of dental care, the amount of the Covered Expense will be equal to the charge for the least expensive procedure. This provision is NOT intended to dictate a course of treatment. Instead, this provision is designed to determine the amount of the plan allowance for a submitted treatment when an adequate and appropriate alternative procedure is available. Accordingly, you may choose to apply the alternate benefit amount determined under this provision toward payment of the submitted treatment.

We may request pre-operative dental x-ray films, periodontal charting and/or additional diagnostic data to determine the plan allowance for the procedures submitted. We strongly encourage pre-treatment estimates so you understand your benefits before any treatment begins. Ask your provider to submit a claim form for this purpose.

EXPENSES INCURRED. An expense is incurred at the time the impression is made for an appliance or change to an appliance. An expense is incurred at the time the tooth or teeth are prepared for a prosthetic crown, appliance, or fixed partial denture. For root canal therapy, an expense is incurred at the time the pulp chamber is opened. All other expenses are incurred at the time the service is rendered or a supply furnished.

LIMITATIONS. Covered Expenses will not include and benefits will not be payable for expenses incurred:

1. in the first 12 months that a person is insured if the person is a Late Entrant; except for evaluations, prophylaxis (cleanings), and fluoride application.

2. for appliances, restorations, or procedures to:

    a. alter vertical dimension;
    b. restore or maintain occlusion; or
    c. splint or replace tooth structure lost as a result of abrasion or attrition.

3. for any procedure begun after the insured person's insurance under this contract terminates.

4. to replace lost or stolen appliances.

5. for any treatment which is for cosmetic purposes.

6. for any procedure not shown in the Table of Dental Procedures. (There may be additional frequencies and limitations that apply, please see the Table of Dental Procedures for details.)

7. for orthodontic treatment under this benefit provision. (If orthodontic expense benefits have been included in this policy, please refer to the Schedule of Benefits and Orthodontic Expense Benefits provision found on 9260).

8. for which the Insured person is entitled to benefits under any workmen’s compensation or similar law, or charges for services or supplies received as a result of any dental condition caused or contributed to by an injury or sickness arising out of or in the course of any employment for wage or profit.

9. for charges which the Insured person is not liable or which would not have been made had no insurance been in force.

10. for services that are not required for necessary care and treatment or are not within the generally accepted parameters of care.

11. because of war or any act of war, declared or not.

TABLE OF DENTAL PROCEDURES

PLEASE READ THE FOLLOWING INFORMATION CAREFULLY FOR YOUR PROCEDURE FREQUENCIES AND PROVISIONS.

The attached is a list of dental procedures for which benefits are payable under this section; and is based upon the Current Dental Terminology, (CDT-5), copyrighted 2004, American Dental Association. **No benefits are payable for a procedure that is not listed.**

Class Number 1

- Your benefits are based on a Calendar Year. A Calendar Year runs from January 1 through December 31.
- Benefit Period means the period from January 1 of any year through December 31 of the same year. But during the first year a person is insured, a benefit period means the period from his or her effective date through December 31 of that year.

Class Number 3

- Your benefits are based on a Calendar Year. A Calendar Year runs from January 1 through December 31.
- Benefit Period means the period from January 1 of any year through December 31 of the same year. But during the first year a person is insured, a benefit period means the period from his or her effective date through December 31 of that year.

Class Number 4

- Your benefits are based on a Calendar Year. A Calendar Year runs from January 1 through December 31.
- Benefit Period means the period from January 1 of any year through December 31 of the same year. But during the first year a person is insured, a benefit period means the period from his or her effective date through December 31 of that year.

All Classes

- Covered Procedures are subject to all plan provisions, procedure and frequency limitations, and/or consultant review.
- Reference to "traumatic injury" under this plan is defined as injury caused by external forces (ie. outside the mouth) and specifically excludes injury caused by internal forces such as bruxism (grinding of teeth).
- Benefits for replacement prosthetic crown, appliance, or fixed partial denture will be based on the prior placement date. Frequencies which reference Benefit Period will be measured forward within the limits defined as the Benefit Period. All other frequencies will be measured forward from the last covered date of service.
- X-ray films, periodontal charting and supporting diagnostic data may be requested for our review.
- We recommend that a pre-treatment estimate be submitted for all anticipated work that is considered to be expensive by our insured.

- A pre-treatment estimate is not a pre-authorization or guarantee of payment or eligibility; rather it is an indication of the estimated benefits available if the described procedures are performed.

Class Number 1

TYPE 1 PROCEDURES

PAYMENT BASIS - Maximum Covered Expense
BENEFIT PERIOD - Calendar Year
For Additional Limitations - See Limitations

		Maximum Covered Expense
ROUTINE ORAL EVALUATION		
D0120	Periodic oral evaluation.	$19.00
D0150	Comprehensive oral evaluation - new or established patient.	$29.00
D0180	Comprehensive periodontal evaluation - new or established patient.	$29.00

COMPREHENSIVE EVALUATION: D0150, D0180

- Coverage is limited to 1 of each of these procedures per 1 provider.
- In addition, D0150, D0180 coverage is limited to 2 of any of these procedures per 1 benefit period.
- D0120, also contribute(s) to this limitation.
- If frequency met, will be considered at an alternate benefit of a D0120 and count toward this frequency.

ROUTINE EVALUATION: D0120

- Coverage is limited to 2 of any of these procedures per 1 benefit period.
- D0150, D0180, also contribute(s) to this limitation.

PROPHYLAXIS (CLEANING) AND FLUORIDE		
D1110	Prophylaxis - adult.	$40.00
D1120	Prophylaxis - child.	$28.00
D1201	Topical application of fluoride (including prophylaxis) - child.	$43.00
D1203	Topical application of fluoride (prophylaxis not included) - child.	$15.00
D1204	Topical application of fluoride (prophylaxis not included) - adult.	$15.00
D1205	Topical application of fluoride (including prophylaxis) - adult.	$55.00

FLUORIDE: D1201, D1203, D1204, D1205

- Coverage is limited to 1 of any of these procedures per 1 benefit period.
- Benefits are considered for persons age 18 and under.
- In addition, D1201, D1205 coverage is limited to 2 of any of these procedures per 1 benefit period.
- D1110, D1120, D4910, also contribute(s) to this limitation.
- The frequency limitation will not be exceeded for either Fluoride or Prophylaxis (cleaning).

PROPHYLAXIS: D1110, D1120

- Coverage is limited to 2 of any of these procedures per 1 benefit period.
- D1201, D1205, D4910, also contribute(s) to this limitation.
- An adult prophylaxis (cleaning) is considered for individuals age 14 and over. A child prophylaxis (cleaning) is considered for individuals age 13 and under. Benefits for prophylaxis (cleaning) are not available when performed on the same date as periodontal procedures.

SPACE MAINTAINERS		
D1510	Space maintainer - fixed - unilateral.	$141.00
D1515	Space maintainer - fixed - bilateral.	$232.00
D1520	Space maintainer - removable - unilateral.	$221.00
D1525	Space maintainer - removable - bilateral.	$270.00
D1550	Re-cementation of space maintainer.	$29.00

SPACE MAINTAINER: D1510, D1515, D1520, D1525

- Coverage is limited to space maintenance for unerupted teeth, following extraction of primary teeth. Allowances include all adjustments within 6 months of placement date.

APPLIANCE THERAPY		
D8210	Removable appliance therapy.	$213.00
D8220	Fixed appliance therapy.	$213.00

APPLIANCE THERAPY: D8210, D8220

- Coverage is limited to the correction of thumb-sucking.

TYPE 2 PROCEDURES
PAYMENT BASIS - Maximum Covered Expense
BENEFIT PERIOD - Calendar Year
For Additional Limitations - See Limitations

		Maximum Covered Expense
LIMITED ORAL EVALUATION		
D0140	Limited oral evaluation - problem focused.	$20.00
D0170	Re-evaluation - limited, problem focused (established patient; not post-operative visit).	$20.00

LIMITED ORAL EVALUATION: D0140, D0170
- Coverage is allowed for accidental injury only. If not due to an accident, will be considered at an alternate benefit of a D0120 and count towards this frequency.

COMPLETE SERIES OR PANORAMIC FILM		
D0210	Intraoral - complete series (including bitewings).	$41.00
D0330	Panoramic film.	$33.00

COMPLETE SERIES/PANORAMIC FILMS: D0210, D0330
- Coverage is limited to 1 of any of these procedures per 3 year(s).

OTHER XRAYS		
D0220	Intraoral - periapical first film.	$8.00
D0230	Intraoral - periapical each additional film.	$6.00
D0240	Intraoral - occlusal film.	$11.00
D0250	Extraoral - first film.	$13.00
D0260	Extraoral - each additional film.	$11.00

PERIAPICAL FILMS: D0220, D0230
- The maximum amount considered for x-ray films taken on one day will be equivalent to an allowance of a D0210.

BITEWING FILMS		
D0270	Bitewing - single film.	$6.00
D0272	Bitewings - two films.	$12.00
D0274	Bitewings - four films.	$18.00
D0277	Vertical bitewings - 7 to 8 films.	$27.00

BITEWING FILMS: D0270, D0272, D0274
- Coverage is limited to 2 of any of these procedures per 1 benefit period.
- D0277, also contribute(s) to this limitation.
- The maximum amount considered for x-ray films taken on one day will be equivalent to an allowance of a D0210.

VERTICAL BITEWING FILM: D0277
- Coverage is limited to 1 of any of these procedures per 3 year(s).
- The maximum amount considered for x-ray films taken on one day will be equivalent to an allowance of a D0210.

ORAL PATHOLOGY/LABORATORY		
D0472	Accession of tissue, gross examination, preparation and transmission of written report.	$25.00
D0473	Accession of tissue, gross and microscopic examination, preparation and transmission of written report.	$48.00
D0474	Accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission of written report.	$48.00

ORAL PATHOLOGY LABORATORY: D0472, D0473, D0474
- Coverage is limited to 1 of any of these procedures per 12 month(s).
- Coverage is limited to 1 examination per biopsy/excision.

SEALANT		
D1351	Sealant - per tooth.	$15.00

SEALANT: D1351
- Coverage is limited to 1 of any of these procedures per 3 year(s).
- Benefits are considered for persons age 16 and under.
- Benefits are considered on permanent molars only.
- Coverage is allowed on the occlusal surface only.

TYPE 2 PROCEDURES

		Maximum Covered Expense
AMALGAM RESTORATIONS (FILLINGS)		
D2140	Amalgam - one surface, primary or permanent.	$35.00
D2150	Amalgam - two surfaces, primary or permanent.	$44.00
D2160	Amalgam - three surfaces, primary or permanent.	$54.00
D2161	Amalgam - four or more surfaces, primary or permanent.	$64.00

AMALGAM RESTORATIONS: D2140, D2150, D2160, D2161

- Coverage is limited to 1 of any of these procedures per 6 month(s).
- D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394, D9911, also contribute(s) to this limitation.

RESIN RESTORATIONS (FILLINGS)		
D2330	Resin-based composite - one surface, anterior.	$43.00
D2331	Resin-based composite - two surfaces, anterior.	$54.00
D2332	Resin-based composite - three surfaces, anterior.	$67.00
D2335	Resin-based composite - four or more surfaces or involving incisal angle (anterior).	$74.00
D2391	Resin-based composite - one surface, posterior.	$47.00
D2392	Resin-based composite - two surfaces, posterior.	$59.00
D2393	Resin-based composite - three surfaces, posterior.	$74.00
D2394	Resin-based composite - four or more surfaces, posterior.	$82.00
D2410	Gold foil - one surface.	$35.00
D2420	Gold foil - two surfaces.	$44.00
D2430	Gold foil - three surfaces.	$54.00

COMPOSITE RESTORATIONS: D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394

- Coverage is limited to 1 of any of these procedures per 6 month(s).
- D2140, D2150, D2160, D2161, D9911, also contribute(s) to this limitation.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.
- Coverage is limited to necessary placement resulting from decay or replacement due to existing unserviceable restorations.

GOLD FOIL RESTORATIONS: D2410, D2420, D2430

- Gold foils are considered at an alternate benefit of an amalgam/composite restoration.

STAINLESS STEEL CROWN (PREFABRICATED CROWN)		
D2390	Resin-based composite crown, anterior.	$90.00
D2930	Prefabricated stainless steel crown - primary tooth.	$76.00
D2931	Prefabricated stainless steel crown - permanent tooth.	$81.00
D2932	Prefabricated resin crown.	$90.00
D2933	Prefabricated stainless steel crown with resin window.	$90.00
D2934	Prefabricated esthetic coated stainless steel crown - primary tooth.	$90.00

STAINLESS STEEL CROWN: D2390, D2930, D2931, D2932, D2933, D2934

- Replacement is limited to 1 of any of these procedures per 12 month(s).
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.

RECEMENT		
D2910	Recement inlay, onlay, or partial coverage restoration.	$28.00
D2915	Recement cast or prefabricated post and core.	$14.00
D2920	Recement crown.	$27.00
D6930	Recement fixed partial denture.	$38.00

SEDATIVE FILLING		
D2940	Sedative filling.	$26.00

FULL MOUTH DEBRIDEMENT		
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis.	$43.00

FULL MOUTH DEBRIDEMENT: D4355

- Coverage is limited to 1 of any of these procedures per 5 year(s).

TYPE 2 PROCEDURES

		Maximum Covered Expense
PERIODONTAL MAINTENANCE		
D4910	Periodontal maintenance.	$44.00

PERIODONTAL MAINTENANCE: D4910

- Coverage is limited to 2 of any of these procedures per 1 benefit period.
- D1110, D1120, D1201, D1205, also contribute(s) to this limitation.
- Coverage is contingent upon evidence of full mouth active periodontal therapy. Benefits are not available if performed on the same date as any other periodontal procedure.

DENTURE REPAIR		
D5510	Repair broken complete denture base.	$44.00
D5520	Replace missing or broken teeth - complete denture (each tooth).	$37.00
D5610	Repair resin denture base.	$44.00
D5620	Repair cast framework.	$52.00
D5630	Repair or replace broken clasp.	$54.00
D5640	Replace broken teeth - per tooth.	$39.00
DENTURE RELINES		
D5730	Reline complete maxillary denture (chairside).	$82.00
D5731	Reline complete mandibular denture (chairside).	$81.00
D5740	Reline maxillary partial denture (chairside).	$73.00
D5741	Reline mandibular partial denture (chairside).	$74.00
D5750	Reline complete maxillary denture (laboratory).	$121.00
D5751	Reline complete mandibular denture (laboratory).	$119.00
D5760	Reline maxillary partial denture (laboratory).	$121.00
D5761	Reline mandibular partial denture (laboratory).	$122.00

DENTURE RELINE: D5730, D5731, D5740, D5741, D5750, D5751, D5760, D5761

- Coverage is limited to service dates more than 6 months after placement date.

NON-SURGICAL EXTRACTIONS		
D7111	Extraction, coronal remnants - deciduous tooth.	$39.00
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal).	$39.00
SURGICAL EXTRACTIONS		
D7210	Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth.	$75.00
D7220	Removal of impacted tooth - soft tissue.	$94.00
D7230	Removal of impacted tooth - partially bony.	$125.00
D7240	Removal of impacted tooth - completely bony.	$146.00
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications.	$166.00
D7250	Surgical removal of residual tooth roots (cutting procedure).	$78.00
OTHER ORAL SURGERY		
D7260	Oroantral fistula closure.	$184.00
D7261	Primary closure of a sinus perforation.	$184.00
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth.	$111.00
D7272	Tooth transplantation (includes reimplantation from one site to another and splinting and/or stabilization).	$111.00
D7280	Surgical access of an unerupted tooth.	$173.00
D7282	Mobilization of erupted or malpositioned tooth to aid eruption.	$124.00
D7283	Placement of device to facilitate eruption of impacted tooth.	$52.00
D7310	Alveoloplasty in conjunction with extractions - per quadrant.	$65.00
D7311	Alveoplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant.	$33.00
D7320	Alveoloplasty not in conjunction with extractions - per quadrant.	$82.00

TYPE 2 PROCEDURES

		Maximum Covered Expense
D7321	Alveoplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant.	$41.00
D7340	Vestibuloplasty - ridge extension (secondary epithelialization).	$119.00
D7350	Vestibuloplasty - ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue).	$296.00
D7410	Excision of benign lesion up to 1.25 cm.	$118.00
D7411	Excision of benign lesion greater than 1.25 cm.	$151.00
D7412	Excision of benign lesion, complicated.	$166.00
D7413	Excision of malignant lesion up to 1.25 cm.	$159.00
D7414	Excision of malignant lesion greater than 1.25 cm.	$117.00
D7415	Excision of malignant lesion, complicated.	$128.00
D7440	Excision of malignant tumor - lesion diameter up to 1.25 cm.	$159.00
D7441	Excision of malignant tumor - lesion diameter greater than 1.25 cm.	$117.00
D7450	Removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25 cm.	$118.00
D7451	Removal of benign odontogenic cyst or tumor - lesion diameter greater than 1.25 cm.	$151.00
D7460	Removal of benign nonodontogenic cyst or tumor - lesion diameter up to 1.25 cm.	$118.00
D7461	Removal of benign nonodontogenic cyst or tumor - lesion diameter greater than 1.25 cm.	$151.00
D7465	Destruction of lesion(s) by physical or chemical method, by report.	$36.00
D7471	Removal of lateral exostosis (maxilla or mandible).	$105.00
D7472	Removal of torus palatinus.	$105.00
D7473	Removal of torus mandibularis.	$105.00
D7485	Surgical reduction of osseous tuberosity.	$171.00
D7490	Radical resection of maxilla or mandible.	$159.00
D7510	Incision and drainage of abscess - intraoral soft tissue.	$53.00
D7520	Incision and drainage of abscess - extraoral soft tissue.	$61.00
D7530	Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue.	$48.00
D7540	Removal of reaction producing foreign bodies, musculoskeletal system.	$133.00
D7550	Partial ostectomy/sequestrectomy for removal of non-vital bone.	$133.00
D7560	Maxillary sinusotomy for removal of tooth fragment or foreign body.	$175.00
D7910	Suture of recent small wounds up to 5 cm.	$23.00
D7911	Complicated suture - up to 5 cm.	$26.00
D7912	Complicated suture - greater than 5 cm.	$38.00
D7960	Frenulectomy (frenectomy or frenotomy) - separate procedure.	$127.00
D7963	Frenuloplasty.	$158.00
D7970	Excision of hyperplastic tissue - per arch.	$97.00
D7972	Surgical reduction of fibrous tuberosity.	$155.00
D7980	Sialolithotomy.	$146.00
D7983	Closure of salivary fistula.	$47.00

REMOVAL OF BONE TISSUE: D7471, D7472, D7473

- Coverage is limited to 5 of any of these procedures per 1 lifetime.

BIOPSY OF ORAL TISSUE

D7285	Biopsy of oral tissue - hard (bone, tooth).	$158.00
D7286	Biopsy of oral tissue - soft.	$85.00
D7287	Exfoliative cytological sample collection.	$43.00
D7288	Brush biopsy - transepithelial sample collection.	$43.00

PALLIATIVE

D9110	Palliative (emergency) treatment of dental pain - minor procedure.	$29.00

PALLIATIVE TREATMENT: D9110

- Not covered in conjunction with other procedures, except diagnostic x-ray films.

TYPE 2 PROCEDURES

		Maximum Covered Expense
ANESTHESIA-GENERAL/IV		
D9220	Deep sedation/general anesthesia - first 30 minutes.	$112.00
D9221	Deep sedation/general anesthesia - each additional 15 minutes.	$37.00
D9241	Intravenous conscious sedation/analgesia - first 30 minutes.	$74.00
D9242	Intravenous conscious sedation/analgesia - each additional 15 minutes.	$18.00

GENERAL ANESTHESIA: D9220, D9221, D9241, D9242

- Coverage is only available with a cutting procedure. Verification of the dentist's anesthesia permit and a copy of the anesthesia report is required. A maximum of two additional units (D9221 or D9242) will be considered.

PROFESSIONAL CONSULT/VISIT/SERVICES		
D9310	Consultation (diagnostic service provided by dentist or physician other than practitioner providing treatment).	$30.00
D9430	Office visit for observation (during regularly scheduled hours) - no other services performed.	$20.00
D9440	Office visit - after regularly scheduled hours.	$36.00
D9930	Treatment of complications (post-surgical) - unusual circumstances, by report.	$22.00

CONSULTATION: D9310

- Coverage is limited to 1 of any of these procedures per 1 provider.

OFFICE VISIT: D9430, D9440

- Procedure D9430 is allowed for accidental injury only. Procedure D9440 will be allowed on the basis of services rendered or visit, whichever is greater.

MISCELLANEOUS		
D2951	Pin retention - per tooth, in addition to restoration.	$13.00
D9911	Application of desensitizing resin for cervical and/or root surfaces, per tooth.	$43.00

DESENSITIZATION: D9911

- Coverage is limited to 1 of any of these procedures per 6 month(s).
- D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394, also contribute(s) to this limitation.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.
- Coverage is limited to necessary placement resulting from decay or replacement due to existing unserviceable restorations.

TYPE 3 PROCEDURES
PAYMENT BASIS - Maximum Covered Expense
BENEFIT PERIOD - Calendar Year
For Additional Limitations - See Limitations

		Maximum Covered Expense
INLAY RESTORATIONS		
D2510	Inlay - metallic - one surface.	$76.00
D2520	Inlay - metallic - two surfaces.	$91.00
D2530	Inlay - metallic - three or more surfaces.	$98.00
D2610	Inlay - porcelain/ceramic - one surface.	$84.00
D2620	Inlay - porcelain/ceramic - two surfaces.	$91.00
D2630	Inlay - porcelain/ceramic - three or more surfaces.	$100.00
D2650	Inlay - resin-based composite - one surface.	$87.00
D2651	Inlay - resin-based composite - two surfaces.	$86.00
D2652	Inlay - resin-based composite - three or more surfaces.	$89.00

INLAY: D2510, D2520, D2530, D2610, D2620, D2630, D2650, D2651, D2652

- Inlays will be considered at an alternate benefit of an amalgam/composite restoration and only when resulting from caries (tooth decay) or traumatic injury.

ONLAY RESTORATIONS		
D2542	Onlay - metallic - two surfaces.	$99.00
D2543	Onlay - metallic - three surfaces.	$110.00
D2544	Onlay - metallic - four or more surfaces.	$115.00
D2642	Onlay - porcelain/ceramic - two surfaces.	$99.00
D2643	Onlay - porcelain/ceramic - three surfaces.	$111.00
D2644	Onlay - porcelain/ceramic - four or more surfaces.	$114.00
D2662	Onlay - resin-based composite - two surfaces.	$93.00
D2663	Onlay - resin-based composite - three surfaces.	$96.00
D2664	Onlay - resin-based composite - four or more surfaces.	$101.00

ONLAY: D2542, D2543, D2544, D2642, D2643, D2644, D2662, D2663, D2664

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- D2510, D2520, D2530, D2610, D2620, D2630, D2650, D2651, D2652, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794, D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792, D6794, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.
- Coverage is limited to necessary placement resulting from caries (tooth decay) or traumatic injury.
- Benefits will not be considered if procedure D2390, D2930, D2931, D2932, D2933 or D2934 has been performed within 12 months.

CROWNS SINGLE RESTORATIONS		
D2710	Crown - resin-based composite (indirect).	$43.00
D2712	Crown - 3/4 resin-based composite (indirect).	$107.00
D2720	Crown - resin with high noble metal.	$110.00
D2721	Crown - resin with predominantly base metal.	$84.00
D2722	Crown - resin with noble metal.	$103.00
D2740	Crown - porcelain/ceramic substrate.	$119.00
D2750	Crown - porcelain fused to high noble metal.	$116.00
D2751	Crown - porcelain fused to predominantly base metal.	$99.00
D2752	Crown - porcelain fused to noble metal.	$106.00
D2780	Crown - 3/4 cast high noble metal.	$110.00
D2781	Crown - 3/4 cast predominantly base metal.	$96.00
D2782	Crown - 3/4 cast noble metal.	$100.00
D2783	Crown - 3/4 porcelain/ceramic.	$119.00

TYPE 3 PROCEDURES

		Maximum Covered Expense
D2790	Crown - full cast high noble metal.	$110.00
D2791	Crown - full cast predominantly base metal.	$96.00
D2792	Crown - full cast noble metal.	$100.00
D2794	Crown - titanium.	$110.00

CROWN: D2710, D2712, D2720, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- D2510, D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2650, D2651, D2652, D2662, D2663, D2664, D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792, D6794, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.
- Coverage is limited to necessary placement resulting from caries (tooth decay) or traumatic injury.
- Benefits will not be considered if procedure D2390, D2930, D2931, D2932, D2933 or D2934 has been performed within 12 months.

CORE BUILD-UP

D2950	Core buildup, including any pins.	$24.00
D6973	Core build up for retainer, including any pins.	$24.00

POST AND CORE

D2952	Cast post and core in addition to crown.	$38.00
D2954	Prefabricated post and core in addition to crown.	$32.00

FIXED CROWN AND PARTIAL DENTURE REPAIR

D2980	Crown repair, by report.	$19.00
D6980	Fixed partial denture repair, by report.	$21.00

ENDODONTICS MISCELLANEOUS

D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament.	$15.00
D3221	Pulpal debridement, primary and permanent teeth.	$15.00
D3230	Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration).	$20.00
D3240	Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration).	$18.00
D3333	Internal root repair of perforation defects.	$25.00
D3351	Apexification/recalcification - initial visit (apical closure/calcific repair of perforations, root resorption, etc.)	$25.00
D3352	Apexication/recalcification - interim medication replacement (apical closure/calcific repair of perforations, root resorption, etc.).	$17.00
D3353	Apexification/recalcification - final visit (includes completed root canal therapy - apical closure/calcific repair of perforations, root resorption, etc.).	$49.00
D3430	Retrograde filling - per root.	$19.00
D3450	Root amputation - per root.	$46.00
D3920	Hemisection (including any root removal), not including root canal therapy.	$39.00

ENDODONTICS MISCELLANEOUS: D3333, D3430, D3450, D3920

- Procedure D3333 is limited to permanent teeth only.

PULPOTOMY/PULPAL DEBRIDEMENT/PULPAL THERAPY: D3220, D3221, D3230, D3240

- Procedure D3220 is limited to primary teeth.

ENDODONTIC THERAPY (ROOT CANALS)

D3310	Anterior (excluding final restoration).	$69.00
D3320	Bicuspid (excluding final restoration).	$81.00
D3330	Molar (excluding final restoration).	$107.00
D3332	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth.	$41.00

TYPE 3 PROCEDURES

		Maximum Covered Expense
D3346	Retreatment of previous root canal therapy - anterior.	$86.00
D3347	Retreatment of previous root canal therapy - bicuspid.	$99.00
D3348	Retreatment of previous root canal therapy - molar.	$123.00

ROOT CANALS: D3310, D3320, D3330, D3332

- Benefits are considered on permanent teeth only.
- Allowances include intraoperative films and cultures but exclude final restoration.

RETREATMENT OF ROOT CANAL: D3346, D3347, D3348

- Coverage is limited to 1 of any of these procedures per 12 month(s).
- D3310, D3320, D3330, also contribute(s) to this limitation.
- Benefits are considered on permanent teeth only.
- Coverage is limited to service dates more than 12 months after root canal therapy. Allowances include intraoperative films and cultures but exclude final restoration.

SURGICAL ENDODONTICS

D3410	Apicoectomy/periradicular surgery - anterior.	$71.00
D3421	Apicoectomy/periradicular surgery - bicuspid (first root).	$82.00
D3425	Apicoectomy/periradicular surgery - molar (first root).	$89.00
D3426	Apicoectomy/periradicular surgery (each additional root).	$32.00

SURGICAL PERIODONTICS

D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or bounded teeth spaces per quadrant.	$45.00
D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth or bounded teeth spaces per quadrant.	$23.00
D4240	Gingival flap procedure, including root planing - four or more contiguous teeth or bounded teeth spaces per quadrant.	$62.00
D4241	Gingival flap procedure, including root planing - one to three contiguous teeth or bounded teeth spaces per quadrant.	$31.00
D4260	Osseous surgery (including flap entry and closure) - four or more contiguous teeth or bounded teeth spaces per quadrant.	$113.00
D4261	Osseous surgery (including flap entry and closure) - one to three contiguous teeth or bounded teeth spaces per quadrant.	$57.00
D4263	Bone replacement graft - first site in quadrant.	$37.00
D4264	Bone replacement graft - each additional site in quadrant.	$28.00
D4265	Biologic materials to aid in soft and osseous tissue regeneration.	$19.00
D4270	Pedicle soft tissue graft procedure.	$84.00
D4271	Free soft tissue graft procedure (including donor site surgery).	$88.00
D4273	Subepithelial connective tissue graft procedures, per tooth.	$103.00
D4274	Distal or proximal wedge procedure (when not performed in conjunction with surgical procedures in the same anatomical area).	$50.00
D4275	Soft tissue allograft.	$88.00
D4276	Combined connective tissue and double pedicle graft, per tooth.	$103.00

BONE GRAFTS: D4263, D4264, D4265

- Each quadrant is limited to 1 of each of these procedures per 3 year(s).
- Coverage is limited to treatment of periodontal disease.

GINGIVECTOMY: D4210, D4211

- Each quadrant is limited to 1 of each of these procedures per 3 year(s).
- Coverage is limited to treatment of periodontal disease.

OSSEOUS SURGERY: D4240, D4241, D4260, D4261

- Each quadrant is limited to 1 of each of these procedures per 3 year(s).
- Coverage is limited to treatment of periodontal disease.

TISSUE GRAFTS: D4270, D4271, D4273, D4275, D4276

- Each quadrant is limited to 2 of any of these procedures per 3 year(s).
- Coverage is limited to treatment of periodontal disease.

CROWN LENGTHENING

D4249	Clinical crown lengthening - hard tissue.	$68.00

TYPE 3 PROCEDURES

		Maximum Covered Expense
NON-SURGICAL PERIODONTICS		
D4341	Periodontal scaling and root planing - four or more teeth per quadrant.	$23.00
D4342	Periodontal scaling and root planing - one to three teeth, per quadrant.	$12.00
D4381	Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth, by report.	$17.00

CHEMOTHERAPEUTIC AGENTS: D4381

- Each quadrant is limited to 2 of any of these procedures per 2 year(s).
- A scaling and root planing or periodontal maintenance procedure must be performed in this quadrant within 2 years prior to the date of service for this procedure.

PERIODONTAL SCALING & ROOT PLANING: D4341, D4342

- Each quadrant is limited to 1 of each of these procedures per 2 year(s).

PROSTHODONTICS - FIXED/REMOVABLE (DENTURES)		
D5110	Complete denture - maxillary.	$123.00
D5120	Complete denture - mandibular.	$119.00
D5130	Immediate denture - maxillary.	$133.00
D5140	Immediate denture - mandibular.	$129.00
D5211	Maxillary partial denture - resin base (including any conventional clasps, rests and teeth).	$89.00
D5212	Mandibular partial denture - resin base (including any conventional clasps, rests and teeth).	$103.00
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth).	$143.00
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth).	$143.00
D5225	Maxillary partial denture - flexible base (including any clasps, rests and teeth).	$89.00
D5226	Mandibular partial denture - flexible base (including any clasps, rests and teeth).	$103.00
D5281	Removable unilateral partial denture - one piece cast metal (including clasps and teeth).	$76.00
D5670	Replace all teeth and acrylic on cast metal framework (maxillary).	$89.00
D5671	Replace all teeth and acrylic on cast metal framework (mandibular).	$103.00
D5810	Interim complete denture (maxillary).	$54.00
D5811	Interim complete denture (mandibular).	$57.00
D5820	Interim partial denture (maxillary).	$48.00
D5821	Interim partial denture (mandibular).	$50.00
D5860	Overdenture - complete, by report.	$123.00
D5861	Overdenture - partial, by report.	$143.00
D6053	Implant/abutment supported removable denture for completely edentulous arch.	$123.00
D6054	Implant/abutment supported removable denture for partially edentulous arch.	$143.00
D6078	Implant/abutment supported fixed denture for completely edentulous arch.	$123.00
D6079	Implant/abutment supported fixed denture for partially edentulous arch.	$143.00

COMPLETE DENTURE: D5110, D5120, D5130, D5140, D5860, D6053, D6078

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- Frequency is waived for accidental injury.
- Allowances include adjustments within 6 months after placement date. Procedures D5860, D6053, and D6078 are considered at an alternate benefit of a D5110/D5120.

PARTIAL DENTURE: D5211, D5212, D5213, D5214, D5225, D5226, D5281, D5670, D5671, D5861, D6054, D6079

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- Frequency is waived for accidental injury.
- Allowances include adjustments within 6 months of placement date. Procedures D5861, D6054, and D6079 are considered at an alternate benefit of a D5213/D5214.

DENTURE ADJUSTMENTS		
D5410	Adjust complete denture - maxillary.	$7.00
D5411	Adjust complete denture - mandibular.	$7.00

TYPE 3 PROCEDURES

		Maximum Covered Expense
D5421	Adjust partial denture - maxillary.	$7.00
D5422	Adjust partial denture - mandibular.	$7.00

DENTURE ADJUSTMENT: D5410, D5411, D5421, D5422

- Coverage is limited to dates of service more than 6 months after placement date.

ADD TOOTH/CLASP TO EXISTING PARTIAL		
D5650	Add tooth to existing partial denture.	$16.00
D5660	Add clasp to existing partial denture.	$19.00
DENTURE REBASES		
D5710	Rebase complete maxillary denture.	$45.00
D5711	Rebase complete mandibular denture.	$47.00
D5720	Rebase maxillary partial denture.	$43.00
D5721	Rebase mandibular partial denture.	$45.00
TISSUE CONDITIONING		
D5850	Tissue conditioning, maxillary.	$13.00
D5851	Tissue conditioning, mandibular.	$13.00
PROSTHODONTICS - FIXED		
D6058	Abutment supported porcelain/ceramic crown.	$103.00
D6059	Abutment supported porcelain fused to metal crown (high noble metal).	$112.00
D6060	Abutment supported porcelain fused to metal crown (predominantly base metal).	$112.00
D6061	Abutment supported porcelain fused to metal crown (noble metal).	$103.00
D6062	Abutment supported cast metal crown (high noble metal).	$112.00
D6063	Abutment supported cast metal crown (predominantly base metal).	$112.00
D6064	Abutment supported cast metal crown (noble metal).	$121.00
D6065	Implant supported porcelain/ceramic crown.	$103.00
D6066	Implant supported porcelain fused to metal crown (titanium, titanium alloy, high noble metal).	$112.00
D6067	Implant supported metal crown (titanium, titanium alloy, high noble metal).	$112.00
D6068	Abutment supported retainer for porcelain/ceramic FPD.	$103.00
D6069	Abutment supported retainer for porcelain fused to metal FPD (high noble metal).	$112.00
D6070	Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal).	$112.00
D6071	Abutment supported retainer for porcelain fused to metal FPD (noble metal).	$103.00
D6072	Abutment supported retainer for cast metal FPD (high noble metal).	$112.00
D6073	Abutment supported retainer for cast metal FPD (predominantly base metal).	$112.00
D6074	Abutment supported retainer for cast metal FPD (noble metal).	$121.00
D6075	Implant supported retainer for ceramic FPD.	$103.00
D6076	Implant supported retainer for porcelain fused to metal FPD (titanium, titanium alloy, or high noble metal).	$112.00
D6077	Implant supported retainer for cast metal FPD (titanium, titanium alloy or high noble metal).	$112.00
D6094	Abutment supported crown - (titanium).	$112.00
D6194	Abutment supported retainer crown for FPD - (titanium).	$112.00
D6205	Pontic - indirect resin based composite.	$93.00
D6210	Pontic - cast high noble metal.	$112.00
D6211	Pontic - cast predominantly base metal.	$112.00
D6212	Pontic - cast noble metal.	$121.00
D6214	Pontic - titanium.	$112.00
D6240	Pontic - porcelain fused to high noble metal.	$112.00
D6241	Pontic - porcelain fused to predominantly base metal.	$112.00

TYPE 3 PROCEDURES

		Maximum Covered Expense
D6242	Pontic - porcelain fused to noble metal.	$103.00
D6245	Pontic - porcelain/ceramic.	$103.00
D6250	Pontic - resin with high noble metal.	$112.00
D6251	Pontic - resin with predominantly base metal.	$103.00
D6252	Pontic - resin with noble metal.	$121.00
D6545	Retainer - cast metal for resin bonded fixed prosthesis.	$37.00
D6548	Retainer - porcelain/ceramic for resin bonded fixed prosthesis.	$37.00
D6600	Inlay - porcelain/ceramic, two surfaces.	$91.00
D6601	Inlay - porcelain/ceramic, three or more surfaces.	$101.00
D6602	Inlay - cast high noble metal, two surfaces.	$82.00
D6603	Inlay - cast high noble metal, three or more surfaces.	$90.00
D6604	Inlay - cast predominantly base metal, two surfaces.	$71.00
D6605	Inlay - cast predominantly base metal, three or more surfaces.	$78.00
D6606	Inlay - cast noble metal, two surfaces.	$75.00
D6607	Inlay - cast noble metal, three or more surfaces.	$82.00
D6608	Onlay - porcelain/ceramic, two surfaces.	$99.00
D6609	Onlay - porcelain/ceramic, three or more surfaces.	$109.00
D6610	Onlay - cast high noble metal, two surfaces.	$90.00
D6611	Onlay - cast high noble metal, three or more surfaces.	$99.00
D6612	Onlay - cast predominantly base metal, two surfaces.	$78.00
D6613	Onlay - cast predominantly base metal, three or more surfaces.	$86.00
D6614	Onlay - cast noble metal, two surfaces.	$82.00
D6615	Onlay - cast noble metal, three or more surfaces.	$90.00
D6624	Inlay - titanium.	$90.00
D6634	Onlay - titanium.	$99.00
D6710	Crown - indirect resin based composite.	$93.00
D6720	Crown - resin with high noble metal.	$112.00
D6721	Crown - resin with predominantly base metal.	$58.00
D6722	Crown - resin with noble metal.	$93.00
D6740	Crown - porcelain/ceramic.	$103.00
D6750	Crown - porcelain fused to high noble metal.	$121.00
D6751	Crown - porcelain fused to predominantly base metal.	$112.00
D6752	Crown - porcelain fused to noble metal.	$103.00
D6780	Crown - 3/4 cast high noble metal.	$121.00
D6781	Crown - 3/4 cast predominantly base metal.	$112.00
D6782	Crown - 3/4 cast noble metal.	$103.00
D6783	Crown - 3/4 porcelain/ceramic.	$103.00
D6790	Crown - full cast high noble metal.	$112.00
D6791	Crown - full cast predominantly base metal.	$112.00
D6792	Crown - full cast noble metal.	$103.00
D6794	Crown - titanium.	$112.00
D6940	Stress breaker.	$31.00

FIXED PARTIAL CROWN: D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792, D6794

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- D2510, D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794, D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.
- Benefits will not be considered if procedure D2390, D2930, D2931, D2932, D2933 or D2934 has been performed within 12 months.

FIXED PARTIAL INLAY: D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6624

TYPE 3 PROCEDURES

Maximum Covered Expense

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- D2510, D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6634, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792, D6794, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.

FIXED PARTIAL ONLAY: D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6634

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- D2510, D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794, D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6624, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792, D6794, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.
- Benefits will not be considered if procedure D2390, D2930, D2931, D2932, D2933 or D2934 has been performed within 12 months.

FIXED PARTIAL PONTIC: D6205, D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6245, D6250, D6251, D6252

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- D5211, D5212, D5213, D5214, D5225, D5226, D5281, D6058, D6059, D6060, D6061, D6062, D6063, D6064, D6065, D6066, D6067, D6068, D6069, D6070, D6071, D6072, D6073, D6074, D6075, D6076, D6077, D6094, D6194, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.

IMPLANT SUPPORTED CROWN: D6058, D6059, D6060, D6061, D6062, D6063, D6064, D6065, D6066, D6067, D6094

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- D5211, D5212, D5213, D5214, D5225, D5226, D5281, D6194, D6205, D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6245, D6250, D6251, D6252, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.

IMPLANT SUPPORTED RETAINER: D6068, D6069, D6070, D6071, D6072, D6073, D6074, D6075, D6076, D6077, D6194

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- D5211, D5212, D5213, D5214, D5225, D5226, D5281, D6058, D6059, D6060, D6061, D6062, D6063, D6064, D6065, D6066, D6067, D6094, D6205, D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6245, D6250, D6251, D6252, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.

CAST POST AND CORE FOR PARTIALS

D6970	Cast post and core in addition to fixed partial denture retainer.	$34.00
D6971	Cast post as part of fixed partial denture retainer.	$34.00
D6972	Prefabricated post and core in addition to fixed partial denture retainer.	$34.00

OCCLUSAL ADJUSTMENT

D9951	Occlusal adjustment - limited.	$9.00
D9952	Occlusal adjustment - complete.	$45.00

OCCLUSAL ADJUSTMENT: D9951, D9952

- Coverage is considered only when performed in conjunction with periodontal procedures for the treatment of periodontal disease.

Class Number 3

TYPE 1 PROCEDURES

PAYMENT BASIS - Maximum Covered Expense
BENEFIT PERIOD - Calendar Year
For Additional Limitations - See Limitations

		Maximum Covered Expense
ROUTINE ORAL EVALUATION		
D0120	Periodic oral evaluation.	$19.00
D0150	Comprehensive oral evaluation - new or established patient.	$29.00
D0180	Comprehensive periodontal evaluation - new or established patient.	$29.00

COMPREHENSIVE EVALUATION: D0150, D0180

- Coverage is limited to 1 of each of these procedures per 1 provider.
- In addition, D0150, D0180 coverage is limited to 2 of any of these procedures per 1 benefit period.
- D0120, also contribute(s) to this limitation.
- If frequency met, will be considered at an alternate benefit of a D0120 and count toward this frequency.

ROUTINE EVALUATION: D0120

- Coverage is limited to 2 of any of these procedures per 1 benefit period.
- D0150, D0180, also contribute(s) to this limitation.

PROPHYLAXIS (CLEANING) AND FLUORIDE		
D1110	Prophylaxis - adult.	$40.00
D1120	Prophylaxis - child.	$28.00
D1201	Topical application of fluoride (including prophylaxis) - child.	$43.00
D1203	Topical application of fluoride (prophylaxis not included) - child.	$15.00
D1204	Topical application of fluoride (prophylaxis not included) - adult.	$15.00
D1205	Topical application of fluoride (including prophylaxis) - adult.	$55.00

FLUORIDE: D1201, D1203, D1204, D1205

- Coverage is limited to 1 of any of these procedures per 1 benefit period.
- Benefits are considered for persons age 18 and under.
- In addition, D1201, D1205 coverage is limited to 2 of any of these procedures per 1 benefit period.
- D1110, D1120, D4910, also contribute(s) to this limitation.
- The frequency limitation will not be exceeded for either Fluoride or Prophylaxis (cleaning).

PROPHYLAXIS: D1110, D1120

- Coverage is limited to 2 of any of these procedures per 1 benefit period.
- D1201, D1205, D4910, also contribute(s) to this limitation.
- An adult prophylaxis (cleaning) is considered for individuals age 14 and over. A child prophylaxis (cleaning) is considered for individuals age 13 and under. Benefits for prophylaxis (cleaning) are not available when performed on the same date as periodontal procedures.

SPACE MAINTAINERS		
D1510	Space maintainer - fixed - unilateral.	$141.00
D1515	Space maintainer - fixed - bilateral.	$232.00
D1520	Space maintainer - removable - unilateral.	$221.00
D1525	Space maintainer - removable - bilateral.	$270.00
D1550	Re-cementation of space maintainer.	$29.00

SPACE MAINTAINER: D1510, D1515, D1520, D1525

- Coverage is limited to space maintenance for unerupted teeth, following extraction of primary teeth. Allowances include all adjustments within 6 months of placement date.

APPLIANCE THERAPY		
D8210	Removable appliance therapy.	$213.00
D8220	Fixed appliance therapy.	$213.00

APPLIANCE THERAPY: D8210, D8220

- Coverage is limited to the correction of thumb-sucking.

TYPE 2 PROCEDURES
PAYMENT BASIS - Maximum Covered Expense
BENEFIT PERIOD - Calendar Year
For Additional Limitations - See Limitations

		Maximum Covered Expense
LIMITED ORAL EVALUATION		
D0140	Limited oral evaluation - problem focused.	$20.00
D0170	Re-evaluation - limited, problem focused (established patient; not post-operative visit).	$20.00

LIMITED ORAL EVALUATION: D0140, D0170
- Coverage is allowed for accidental injury only. If not due to an accident, will be considered at an alternate benefit of a D0120 and count towards this frequency.

COMPLETE SERIES OR PANORAMIC FILM		
D0210	Intraoral - complete series (including bitewings).	$41.00
D0330	Panoramic film.	$33.00

COMPLETE SERIES/PANORAMIC FILMS: D0210, D0330
- Coverage is limited to 1 of any of these procedures per 3 year(s).

OTHER XRAYS		
D0220	Intraoral - periapical first film.	$8.00
D0230	Intraoral - periapical each additional film.	$6.00
D0240	Intraoral - occlusal film.	$11.00
D0250	Extraoral - first film.	$13.00
D0260	Extraoral - each additional film.	$11.00

PERIAPICAL FILMS: D0220, D0230
- The maximum amount considered for x-ray films taken on one day will be equivalent to an allowance of a D0210.

BITEWING FILMS		
D0270	Bitewing - single film.	$6.00
D0272	Bitewings - two films.	$12.00
D0274	Bitewings - four films.	$18.00
D0277	Vertical bitewings - 7 to 8 films.	$27.00

BITEWING FILMS: D0270, D0272, D0274
- Coverage is limited to 2 of any of these procedures per 1 benefit period.
- D0277, also contribute(s) to this limitation.
- The maximum amount considered for x-ray films taken on one day will be equivalent to an allowance of a D0210.

VERTICAL BITEWING FILM: D0277
- Coverage is limited to 1 of any of these procedures per 3 year(s).
- The maximum amount considered for x-ray films taken on one day will be equivalent to an allowance of a D0210.

ORAL PATHOLOGY/LABORATORY		
D0472	Accession of tissue, gross examination, preparation and transmission of written report.	$25.00
D0473	Accession of tissue, gross and microscopic examination, preparation and transmission of written report.	$48.00
D0474	Accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission of written report.	$48.00

ORAL PATHOLOGY LABORATORY: D0472, D0473, D0474
- Coverage is limited to 1 of any of these procedures per 12 month(s).
- Coverage is limited to 1 examination per biopsy/excision.

SEALANT		
D1351	Sealant - per tooth.	$15.00

SEALANT: D1351
- Coverage is limited to 1 of any of these procedures per 3 year(s).
- Benefits are considered for persons age 16 and under.
- Benefits are considered on permanent molars only.
- Coverage is allowed on the occlusal surface only.

TYPE 2 PROCEDURES

		Maximum Covered Expense
AMALGAM RESTORATIONS (FILLINGS)		
D2140	Amalgam - one surface, primary or permanent.	$35.00
D2150	Amalgam - two surfaces, primary or permanent.	$44.00
D2160	Amalgam - three surfaces, primary or permanent.	$54.00
D2161	Amalgam - four or more surfaces, primary or permanent.	$64.00

AMALGAM RESTORATIONS: D2140, D2150, D2160, D2161

- Coverage is limited to 1 of any of these procedures per 6 month(s).
- D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394, D9911, also contribute(s) to this limitation.

RESIN RESTORATIONS (FILLINGS)		
D2330	Resin-based composite - one surface, anterior.	$43.00
D2331	Resin-based composite - two surfaces, anterior.	$54.00
D2332	Resin-based composite - three surfaces, anterior.	$67.00
D2335	Resin-based composite - four or more surfaces or involving incisal angle (anterior).	$74.00
D2391	Resin-based composite - one surface, posterior.	$47.00
D2392	Resin-based composite - two surfaces, posterior.	$59.00
D2393	Resin-based composite - three surfaces, posterior.	$74.00
D2394	Resin-based composite - four or more surfaces, posterior.	$82.00
D2410	Gold foil - one surface.	$35.00
D2420	Gold foil - two surfaces.	$44.00
D2430	Gold foil - three surfaces.	$54.00

COMPOSITE RESTORATIONS: D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394

- Coverage is limited to 1 of any of these procedures per 6 month(s).
- D2140, D2150, D2160, D2161, D9911, also contribute(s) to this limitation.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.
- Coverage is limited to necessary placement resulting from decay or replacement due to existing unserviceable restorations.

GOLD FOIL RESTORATIONS: D2410, D2420, D2430

- Gold foils are considered at an alternate benefit of an amalgam/composite restoration.

STAINLESS STEEL CROWN (PREFABRICATED CROWN)		
D2390	Resin-based composite crown, anterior.	$90.00
D2930	Prefabricated stainless steel crown - primary tooth.	$76.00
D2931	Prefabricated stainless steel crown - permanent tooth.	$81.00
D2932	Prefabricated resin crown.	$90.00
D2933	Prefabricated stainless steel crown with resin window.	$90.00
D2934	Prefabricated esthetic coated stainless steel crown - primary tooth.	$90.00

STAINLESS STEEL CROWN: D2390, D2930, D2931, D2932, D2933, D2934

- Replacement is limited to 1 of any of these procedures per 12 month(s).
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.

RECEMENT		
D2910	Recement inlay, onlay, or partial coverage restoration.	$28.00
D2915	Recement cast or prefabricated post and core.	$14.00
D2920	Recement crown.	$27.00
D6930	Recement fixed partial denture.	$38.00

SEDATIVE FILLING		
D2940	Sedative filling.	$26.00

FULL MOUTH DEBRIDEMENT		
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis.	$43.00

FULL MOUTH DEBRIDEMENT: D4355

- Coverage is limited to 1 of any of these procedures per 5 year(s).

TYPE 2 PROCEDURES

		Maximum Covered Expense
PERIODONTAL MAINTENANCE		
D4910	Periodontal maintenance.	$44.00

PERIODONTAL MAINTENANCE: D4910

- Coverage is limited to 2 of any of these procedures per 1 benefit period.
- D1110, D1120, D1201, D1205, also contribute(s) to this limitation.
- Coverage is contingent upon evidence of full mouth active periodontal therapy. Benefits are not available if performed on the same date as any other periodontal procedure.

DENTURE REPAIR		
D5510	Repair broken complete denture base.	$44.00
D5520	Replace missing or broken teeth - complete denture (each tooth).	$37.00
D5610	Repair resin denture base.	$44.00
D5620	Repair cast framework.	$52.00
D5630	Repair or replace broken clasp.	$54.00
D5640	Replace broken teeth - per tooth.	$39.00
DENTURE RELINES		
D5730	Reline complete maxillary denture (chairside).	$82.00
D5731	Reline complete mandibular denture (chairside).	$81.00
D5740	Reline maxillary partial denture (chairside).	$73.00
D5741	Reline mandibular partial denture (chairside).	$74.00
D5750	Reline complete maxillary denture (laboratory).	$121.00
D5751	Reline complete mandibular denture (laboratory).	$119.00
D5760	Reline maxillary partial denture (laboratory).	$121.00
D5761	Reline mandibular partial denture (laboratory).	$122.00

DENTURE RELINE: D5730, D5731, D5740, D5741, D5750, D5751, D5760, D5761

- Coverage is limited to service dates more than 6 months after placement date.

NON-SURGICAL EXTRACTIONS		
D7111	Extraction, coronal remnants - deciduous tooth.	$39.00
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal).	$39.00
SURGICAL EXTRACTIONS		
D7210	Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth.	$75.00
D7220	Removal of impacted tooth - soft tissue.	$94.00
D7230	Removal of impacted tooth - partially bony.	$125.00
D7240	Removal of impacted tooth - completely bony.	$146.00
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications.	$166.00
D7250	Surgical removal of residual tooth roots (cutting procedure).	$78.00
OTHER ORAL SURGERY		
D7260	Oroantral fistula closure.	$184.00
D7261	Primary closure of a sinus perforation.	$184.00
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth.	$111.00
D7272	Tooth transplantation (includes reimplantation from one site to another and splinting and/or stabilization).	$111.00
D7280	Surgical access of an unerupted tooth.	$173.00
D7282	Mobilization of erupted or malpositioned tooth to aid eruption.	$124.00
D7283	Placement of device to facilitate eruption of impacted tooth.	$52.00
D7310	Alveoloplasty in conjunction with extractions - per quadrant.	$65.00
D7311	Alveoplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant.	$33.00
D7320	Alveoloplasty not in conjunction with extractions - per quadrant.	$82.00

TYPE 2 PROCEDURES

		Maximum Covered Expense
D7321	Alveoplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant.	$41.00
D7340	Vestibuloplasty - ridge extension (secondary epithelialization).	$119.00
D7350	Vestibuloplasty - ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue).	$296.00
D7410	Excision of benign lesion up to 1.25 cm.	$118.00
D7411	Excision of benign lesion greater than 1.25 cm.	$151.00
D7412	Excision of benign lesion, complicated.	$166.00
D7413	Excision of malignant lesion up to 1.25 cm.	$159.00
D7414	Excision of malignant lesion greater than 1.25 cm.	$117.00
D7415	Excision of malignant lesion, complicated.	$128.00
D7440	Excision of malignant tumor - lesion diameter up to 1.25 cm.	$159.00
D7441	Excision of malignant tumor - lesion diameter greater than 1.25 cm.	$117.00
D7450	Removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25 cm.	$118.00
D7451	Removal of benign odontogenic cyst or tumor - lesion diameter greater than 1.25 cm.	$151.00
D7460	Removal of benign nonodontogenic cyst or tumor - lesion diameter up to 1.25 cm.	$118.00
D7461	Removal of benign nonodontogenic cyst or tumor - lesion diameter greater than 1.25 cm.	$151.00
D7465	Destruction of lesion(s) by physical or chemical method, by report.	$36.00
D7471	Removal of lateral exostosis (maxilla or mandible).	$105.00
D7472	Removal of torus palatinus.	$105.00
D7473	Removal of torus mandibularis.	$105.00
D7485	Surgical reduction of osseous tuberosity.	$171.00
D7490	Radical resection of maxilla or mandible.	$159.00
D7510	Incision and drainage of abscess - intraoral soft tissue.	$53.00
D7520	Incision and drainage of abscess - extraoral soft tissue.	$61.00
D7530	Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue.	$48.00
D7540	Removal of reaction producing foreign bodies, musculoskeletal system.	$133.00
D7550	Partial ostectomy/sequestrectomy for removal of non-vital bone.	$133.00
D7560	Maxillary sinusotomy for removal of tooth fragment or foreign body.	$175.00
D7910	Suture of recent small wounds up to 5 cm.	$23.00
D7911	Complicated suture - up to 5 cm.	$26.00
D7912	Complicated suture - greater than 5 cm.	$38.00
D7960	Frenulectomy (frenectomy or frenotomy) - separate procedure.	$127.00
D7963	Frenuloplasty.	$158.00
D7970	Excision of hyperplastic tissue - per arch.	$97.00
D7972	Surgical reduction of fibrous tuberosity.	$155.00
D7980	Sialolithotomy.	$146.00
D7983	Closure of salivary fistula.	$47.00

REMOVAL OF BONE TISSUE: D7471, D7472, D7473

- Coverage is limited to 5 of any of these procedures per 1 lifetime.

BIOPSY OF ORAL TISSUE

D7285	Biopsy of oral tissue - hard (bone, tooth).	$158.00
D7286	Biopsy of oral tissue - soft.	$85.00
D7287	Exfoliative cytological sample collection.	$43.00
D7288	Brush biopsy - transepithelial sample collection.	$43.00

PALLIATIVE

D9110	Palliative (emergency) treatment of dental pain - minor procedure.	$29.00

PALLIATIVE TREATMENT: D9110

- Not covered in conjunction with other procedures, except diagnostic x-ray films.

TYPE 2 PROCEDURES

		Maximum Covered Expense
ANESTHESIA-GENERAL/IV		
D9220	Deep sedation/general anesthesia - first 30 minutes.	$112.00
D9221	Deep sedation/general anesthesia - each additional 15 minutes.	$37.00
D9241	Intravenous conscious sedation/analgesia - first 30 minutes.	$74.00
D9242	Intravenous conscious sedation/analgesia - each additional 15 minutes.	$18.00

GENERAL ANESTHESIA: D9220, D9221, D9241, D9242

- Coverage is only available with a cutting procedure. Verification of the dentist's anesthesia permit and a copy of the anesthesia report is required. A maximum of two additional units (D9221 or D9242) will be considered.

PROFESSIONAL CONSULT/VISIT/SERVICES		
D9310	Consultation (diagnostic service provided by dentist or physician other than practitioner providing treatment).	$30.00
D9430	Office visit for observation (during regularly scheduled hours) - no other services performed.	$20.00
D9440	Office visit - after regularly scheduled hours.	$36.00
D9930	Treatment of complications (post-surgical) - unusual circumstances, by report.	$22.00

CONSULTATION: D9310

- Coverage is limited to 1 of any of these procedures per 1 provider.

OFFICE VISIT: D9430, D9440

- Procedure D9430 is allowed for accidental injury only. Procedure D9440 will be allowed on the basis of services rendered or visit, whichever is greater.

MISCELLANEOUS		
D2951	Pin retention - per tooth, in addition to restoration.	$13.00
D9911	Application of desensitizing resin for cervical and/or root surfaces, per tooth.	$43.00

DESENSITIZATION: D9911

- Coverage is limited to 1 of any of these procedures per 6 month(s).
- D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394, also contribute(s) to this limitation.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.
- Coverage is limited to necessary placement resulting from decay or replacement due to existing unserviceable restorations.

TYPE 3 PROCEDURES
PAYMENT BASIS - Maximum Covered Expense
BENEFIT PERIOD - Calendar Year
For Additional Limitations - See Limitations

		Maximum Covered Expense
INLAY RESTORATIONS		
D2510	Inlay - metallic - one surface.	$76.00
D2520	Inlay - metallic - two surfaces.	$91.00
D2530	Inlay - metallic - three or more surfaces.	$98.00
D2610	Inlay - porcelain/ceramic - one surface.	$84.00
D2620	Inlay - porcelain/ceramic - two surfaces.	$91.00
D2630	Inlay - porcelain/ceramic - three or more surfaces.	$100.00
D2650	Inlay - resin-based composite - one surface.	$87.00
D2651	Inlay - resin-based composite - two surfaces.	$86.00
D2652	Inlay - resin-based composite - three or more surfaces.	$89.00

INLAY: D2510, D2520, D2530, D2610, D2620, D2630, D2650, D2651, D2652

- Inlays will be considered at an alternate benefit of an amalgam/composite restoration and only when resulting from caries (tooth decay) or traumatic injury.

ONLAY RESTORATIONS		
D2542	Onlay - metallic - two surfaces.	$99.00
D2543	Onlay - metallic - three surfaces.	$110.00
D2544	Onlay - metallic - four or more surfaces.	$115.00
D2642	Onlay - porcelain/ceramic - two surfaces.	$99.00
D2643	Onlay - porcelain/ceramic - three surfaces.	$111.00
D2644	Onlay - porcelain/ceramic - four or more surfaces.	$114.00
D2662	Onlay - resin-based composite - two surfaces.	$93.00
D2663	Onlay - resin-based composite - three surfaces.	$96.00
D2664	Onlay - resin-based composite - four or more surfaces.	$101.00

ONLAY: D2542, D2543, D2544, D2642, D2643, D2644, D2662, D2663, D2664

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- D2510, D2520, D2530, D2610, D2620, D2630, D2650, D2651, D2652, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794, D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792, D6794, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.
- Coverage is limited to necessary placement resulting from caries (tooth decay) or traumatic injury.
- Benefits will not be considered if procedure D2390, D2930, D2931, D2932, D2933 or D2934 has been performed within 12 months.

CROWNS SINGLE RESTORATIONS		
D2710	Crown - resin-based composite (indirect).	$43.00
D2712	Crown - 3/4 resin-based composite (indirect).	$107.00
D2720	Crown - resin with high noble metal.	$110.00
D2721	Crown - resin with predominantly base metal.	$84.00
D2722	Crown - resin with noble metal.	$103.00
D2740	Crown - porcelain/ceramic substrate.	$119.00
D2750	Crown - porcelain fused to high noble metal.	$116.00
D2751	Crown - porcelain fused to predominantly base metal.	$99.00
D2752	Crown - porcelain fused to noble metal.	$106.00
D2780	Crown - 3/4 cast high noble metal.	$110.00
D2781	Crown - 3/4 cast predominantly base metal.	$96.00
D2782	Crown - 3/4 cast noble metal.	$100.00
D2783	Crown - 3/4 porcelain/ceramic.	$119.00

TYPE 3 PROCEDURES

		Maximum Covered Expense
D2790	Crown - full cast high noble metal.	$110.00
D2791	Crown - full cast predominantly base metal.	$96.00
D2792	Crown - full cast noble metal.	$100.00
D2794	Crown - titanium.	$110.00

CROWN: D2710, D2712, D2720, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- D2510, D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2650, D2651, D2652, D2662, D2663, D2664, D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792, D6794, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.
- Coverage is limited to necessary placement resulting from caries (tooth decay) or traumatic injury.
- Benefits will not be considered if procedure D2390, D2930, D2931, D2932, D2933 or D2934 has been performed within 12 months.

CORE BUILD-UP

D2950	Core buildup, including any pins.	$24.00
D6973	Core build up for retainer, including any pins.	$24.00

POST AND CORE

D2952	Cast post and core in addition to crown.	$38.00
D2954	Prefabricated post and core in addition to crown.	$32.00

FIXED CROWN AND PARTIAL DENTURE REPAIR

D2980	Crown repair, by report.	$19.00
D6980	Fixed partial denture repair, by report.	$21.00

ENDODONTICS MISCELLANEOUS

D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament.	$15.00
D3221	Pulpal debridement, primary and permanent teeth.	$15.00
D3230	Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration).	$20.00
D3240	Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration).	$18.00
D3333	Internal root repair of perforation defects.	$25.00
D3351	Apexification/recalcification - initial visit (apical closure/calcific repair of perforations, root resorption, etc.)	$25.00
D3352	Apexication/recalcification - interim medication replacement (apical closure/calcific repair of perforations, root resorption, etc.).	$17.00
D3353	Apexification/recalcification - final visit (includes completed root canal therapy - apical closure/calcific repair of perforations, root resorption, etc.).	$49.00
D3430	Retrograde filling - per root.	$19.00
D3450	Root amputation - per root.	$46.00
D3920	Hemisection (including any root removal), not including root canal therapy.	$39.00

ENDODONTICS MISCELLANEOUS: D3333, D3430, D3450, D3920

- Procedure D3333 is limited to permanent teeth only.

PULPOTOMY/PULPAL DEBRIDEMENT/PULPAL THERAPY: D3220, D3221, D3230, D3240

- Procedure D3220 is limited to primary teeth.

ENDODONTIC THERAPY (ROOT CANALS)

D3310	Anterior (excluding final restoration).	$69.00
D3320	Bicuspid (excluding final restoration).	$81.00
D3330	Molar (excluding final restoration).	$107.00
D3332	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth.	$41.00

TYPE 3 PROCEDURES

		Maximum Covered Expense
D3346	Retreatment of previous root canal therapy - anterior.	$86.00
D3347	Retreatment of previous root canal therapy - bicuspid.	$99.00
D3348	Retreatment of previous root canal therapy - molar.	$123.00

ROOT CANALS: D3310, D3320, D3330, D3332

- Benefits are considered on permanent teeth only.
- Allowances include intraoperative films and cultures but exclude final restoration.

RETREATMENT OF ROOT CANAL: D3346, D3347, D3348

- Coverage is limited to 1 of any of these procedures per 12 month(s).
- D3310, D3320, D3330, also contribute(s) to this limitation.
- Benefits are considered on permanent teeth only.
- Coverage is limited to service dates more than 12 months after root canal therapy. Allowances include intraoperative films and cultures but exclude final restoration.

SURGICAL ENDODONTICS

D3410	Apicoectomy/periradicular surgery - anterior.	$71.00
D3421	Apicoectomy/periradicular surgery - bicuspid (first root).	$82.00
D3425	Apicoectomy/periradicular surgery - molar (first root).	$89.00
D3426	Apicoectomy/periradicular surgery (each additional root).	$32.00

SURGICAL PERIODONTICS

D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or bounded teeth spaces per quadrant.	$45.00
D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth or bounded teeth spaces per quadrant.	$23.00
D4240	Gingival flap procedure, including root planing - four or more contiguous teeth or bounded teeth spaces per quadrant.	$62.00
D4241	Gingival flap procedure, including root planing - one to three contiguous teeth or bounded teeth spaces per quadrant.	$31.00
D4260	Osseous surgery (including flap entry and closure) - four or more contiguous teeth or bounded teeth spaces per quadrant.	$113.00
D4261	Osseous surgery (including flap entry and closure) - one to three contiguous teeth or bounded teeth spaces per quadrant.	$57.00
D4263	Bone replacement graft - first site in quadrant.	$37.00
D4264	Bone replacement graft - each additional site in quadrant.	$28.00
D4265	Biologic materials to aid in soft and osseous tissue regeneration.	$19.00
D4270	Pedicle soft tissue graft procedure.	$84.00
D4271	Free soft tissue graft procedure (including donor site surgery).	$88.00
D4273	Subepithelial connective tissue graft procedures, per tooth.	$103.00
D4274	Distal or proximal wedge procedure (when not performed in conjunction with surgical procedures in the same anatomical area).	$50.00
D4275	Soft tissue allograft.	$88.00
D4276	Combined connective tissue and double pedicle graft, per tooth.	$103.00

BONE GRAFTS: D4263, D4264, D4265

- Each quadrant is limited to 1 of each of these procedures per 3 year(s).
- Coverage is limited to treatment of periodontal disease.

GINGIVECTOMY: D4210, D4211

- Each quadrant is limited to 1 of each of these procedures per 3 year(s).
- Coverage is limited to treatment of periodontal disease.

OSSEOUS SURGERY: D4240, D4241, D4260, D4261

- Each quadrant is limited to 1 of each of these procedures per 3 year(s).
- Coverage is limited to treatment of periodontal disease.

TISSUE GRAFTS: D4270, D4271, D4273, D4275, D4276

- Each quadrant is limited to 2 of any of these procedures per 3 year(s).
- Coverage is limited to treatment of periodontal disease.

CROWN LENGTHENING

D4249	Clinical crown lengthening - hard tissue.	$68.00

TYPE 3 PROCEDURES

		Maximum Covered Expense
NON-SURGICAL PERIODONTICS		
D4341	Periodontal scaling and root planing - four or more teeth per quadrant.	$23.00
D4342	Periodontal scaling and root planing - one to three teeth, per quadrant.	$12.00
D4381	Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth, by report.	$17.00

CHEMOTHERAPEUTIC AGENTS: D4381

- Each quadrant is limited to 2 of any of these procedures per 2 year(s).
- A scaling and root planing or periodontal maintenance procedure must be performed in this quadrant within 2 years prior to the date of service for this procedure.

PERIODONTAL SCALING & ROOT PLANING: D4341, D4342

- Each quadrant is limited to 1 of each of these procedures per 2 year(s).

PROSTHODONTICS - FIXED/REMOVABLE (DENTURES)		
D5110	Complete denture - maxillary.	$123.00
D5120	Complete denture - mandibular.	$119.00
D5130	Immediate denture - maxillary.	$133.00
D5140	Immediate denture - mandibular.	$129.00
D5211	Maxillary partial denture - resin base (including any conventional clasps, rests and teeth).	$89.00
D5212	Mandibular partial denture - resin base (including any conventional clasps, rests and teeth).	$103.00
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth).	$143.00
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth).	$143.00
D5225	Maxillary partial denture - flexible base (including any clasps, rests and teeth).	$89.00
D5226	Mandibular partial denture - flexible base (including any clasps, rests and teeth).	$103.00
D5281	Removable unilateral partial denture - one piece cast metal (including clasps and teeth).	$76.00
D5670	Replace all teeth and acrylic on cast metal framework (maxillary).	$89.00
D5671	Replace all teeth and acrylic on cast metal framework (mandibular).	$103.00
D5810	Interim complete denture (maxillary).	$54.00
D5811	Interim complete denture (mandibular).	$57.00
D5820	Interim partial denture (maxillary).	$48.00
D5821	Interim partial denture (mandibular).	$50.00
D5860	Overdenture - complete, by report.	$123.00
D5861	Overdenture - partial, by report.	$143.00
D6053	Implant/abutment supported removable denture for completely edentulous arch.	$123.00
D6054	Implant/abutment supported removable denture for partially edentulous arch.	$143.00
D6078	Implant/abutment supported fixed denture for completely edentulous arch.	$123.00
D6079	Implant/abutment supported fixed denture for partially edentulous arch.	$143.00

COMPLETE DENTURE: D5110, D5120, D5130, D5140, D5860, D6053, D6078

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- Frequency is waived for accidental injury.
- Allowances include adjustments within 6 months after placement date. Procedures D5860, D6053, and D6078 are considered at an alternate benefit of a D5110/D5120.

PARTIAL DENTURE: D5211, D5212, D5213, D5214, D5225, D5226, D5281, D5670, D5671, D5861, D6054, D6079

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- Frequency is waived for accidental injury.
- Allowances include adjustments within 6 months of placement date. Procedures D5861, D6054, and D6079 are considered at an alternate benefit of a D5213/D5214.

DENTURE ADJUSTMENTS		
D5410	Adjust complete denture - maxillary.	$7.00
D5411	Adjust complete denture - mandibular.	$7.00

TYPE 3 PROCEDURES

		Maximum Covered Expense
D5421	Adjust partial denture - maxillary.	$7.00
D5422	Adjust partial denture - mandibular.	$7.00

DENTURE ADJUSTMENT: D5410, D5411, D5421, D5422

- Coverage is limited to dates of service more than 6 months after placement date.

ADD TOOTH/CLASP TO EXISTING PARTIAL

D5650	Add tooth to existing partial denture.	$16.00
D5660	Add clasp to existing partial denture.	$19.00

DENTURE REBASES

D5710	Rebase complete maxillary denture.	$45.00
D5711	Rebase complete mandibular denture.	$47.00
D5720	Rebase maxillary partial denture.	$43.00
D5721	Rebase mandibular partial denture.	$45.00

TISSUE CONDITIONING

D5850	Tissue conditioning, maxillary.	$13.00
D5851	Tissue conditioning, mandibular.	$13.00

PROSTHODONTICS - FIXED

D6058	Abutment supported porcelain/ceramic crown.	$103.00
D6059	Abutment supported porcelain fused to metal crown (high noble metal).	$112.00
D6060	Abutment supported porcelain fused to metal crown (predominantly base metal).	$112.00
D6061	Abutment supported porcelain fused to metal crown (noble metal).	$103.00
D6062	Abutment supported cast metal crown (high noble metal).	$112.00
D6063	Abutment supported cast metal crown (predominantly base metal).	$112.00
D6064	Abutment supported cast metal crown (noble metal).	$121.00
D6065	Implant supported porcelain/ceramic crown.	$103.00
D6066	Implant supported porcelain fused to metal crown (titanium, titanium alloy, high noble metal).	$112.00
D6067	Implant supported metal crown (titanium, titanium alloy, high noble metal).	$112.00
D6068	Abutment supported retainer for porcelain/ceramic FPD.	$103.00
D6069	Abutment supported retainer for porcelain fused to metal FPD (high noble metal).	$112.00
D6070	Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal).	$112.00
D6071	Abutment supported retainer for porcelain fused to metal FPD (noble metal).	$103.00
D6072	Abutment supported retainer for cast metal FPD (high noble metal).	$112.00
D6073	Abutment supported retainer for cast metal FPD (predominantly base metal).	$112.00
D6074	Abutment supported retainer for cast metal FPD (noble metal).	$121.00
D6075	Implant supported retainer for ceramic FPD.	$103.00
D6076	Implant supported retainer for porcelain fused to metal FPD (titanium, titanium alloy, or high noble metal).	$112.00
D6077	Implant supported retainer for cast metal FPD (titanium, titanium alloy or high noble metal).	$112.00
D6094	Abutment supported crown - (titanium).	$112.00
D6194	Abutment supported retainer crown for FPD - (titanium).	$112.00
D6205	Pontic - indirect resin based composite.	$93.00
D6210	Pontic - cast high noble metal.	$112.00
D6211	Pontic - cast predominantly base metal.	$112.00
D6212	Pontic - cast noble metal.	$121.00
D6214	Pontic - titanium.	$112.00
D6240	Pontic - porcelain fused to high noble metal.	$112.00
D6241	Pontic - porcelain fused to predominantly base metal.	$112.00

TYPE 3 PROCEDURES

		Maximum Covered Expense
D6242	Pontic - porcelain fused to noble metal.	$103.00
D6245	Pontic - porcelain/ceramic.	$103.00
D6250	Pontic - resin with high noble metal.	$112.00
D6251	Pontic - resin with predominantly base metal.	$103.00
D6252	Pontic - resin with noble metal.	$121.00
D6545	Retainer - cast metal for resin bonded fixed prosthesis.	$37.00
D6548	Retainer - porcelain/ceramic for resin bonded fixed prosthesis.	$37.00
D6600	Inlay - porcelain/ceramic, two surfaces.	$91.00
D6601	Inlay - porcelain/ceramic, three or more surfaces.	$101.00
D6602	Inlay - cast high noble metal, two surfaces.	$82.00
D6603	Inlay - cast high noble metal, three or more surfaces.	$90.00
D6604	Inlay - cast predominantly base metal, two surfaces.	$71.00
D6605	Inlay - cast predominantly base metal, three or more surfaces.	$78.00
D6606	Inlay - cast noble metal, two surfaces.	$75.00
D6607	Inlay - cast noble metal, three or more surfaces.	$82.00
D6608	Onlay - porcelain/ceramic, two surfaces.	$99.00
D6609	Onlay - porcelain/ceramic, three or more surfaces.	$109.00
D6610	Onlay - cast high noble metal, two surfaces.	$90.00
D6611	Onlay - cast high noble metal, three or more surfaces.	$99.00
D6612	Onlay - cast predominantly base metal, two surfaces.	$78.00
D6613	Onlay - cast predominantly base metal, three or more surfaces.	$86.00
D6614	Onlay - cast noble metal, two surfaces.	$82.00
D6615	Onlay - cast noble metal, three or more surfaces.	$90.00
D6624	Inlay - titanium.	$90.00
D6634	Onlay - titanium.	$99.00
D6710	Crown - indirect resin based composite.	$93.00
D6720	Crown - resin with high noble metal.	$112.00
D6721	Crown - resin with predominantly base metal.	$58.00
D6722	Crown - resin with noble metal.	$93.00
D6740	Crown - porcelain/ceramic.	$103.00
D6750	Crown - porcelain fused to high noble metal.	$121.00
D6751	Crown - porcelain fused to predominantly base metal.	$112.00
D6752	Crown - porcelain fused to noble metal.	$103.00
D6780	Crown - 3/4 cast high noble metal.	$121.00
D6781	Crown - 3/4 cast predominantly base metal.	$112.00
D6782	Crown - 3/4 cast noble metal.	$103.00
D6783	Crown - 3/4 porcelain/ceramic.	$103.00
D6790	Crown - full cast high noble metal.	$112.00
D6791	Crown - full cast predominantly base metal.	$112.00
D6792	Crown - full cast noble metal.	$103.00
D6794	Crown - titanium.	$112.00
D6940	Stress breaker.	$31.00

FIXED PARTIAL CROWN: D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792, D6794

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- D2510, D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794, D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.
- Benefits will not be considered if procedure D2390, D2930, D2931, D2932, D2933 or D2934 has been performed within 12 months.

FIXED PARTIAL INLAY: D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6624

TYPE 3 PROCEDURES

Maximum Covered Expense

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- D2510, D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6634, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792, D6794, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.

FIXED PARTIAL ONLAY: D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6634

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- D2510, D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794, D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6624, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790, D6791, D6792, D6794, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.
- Benefits will not be considered if procedure D2390, D2930, D2931, D2932, D2933 or D2934 has been performed within 12 months.

FIXED PARTIAL PONTIC: D6205, D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6245, D6250, D6251, D6252

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- D5211, D5212, D5213, D5214, D5225, D5226, D5281, D6058, D6059, D6060, D6061, D6062, D6063, D6064, D6065, D6066, D6067, D6068, D6069, D6070, D6071, D6072, D6073, D6074, D6075, D6076, D6077, D6094, D6194, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.

IMPLANT SUPPORTED CROWN: D6058, D6059, D6060, D6061, D6062, D6063, D6064, D6065, D6066, D6067, D6094

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- D5211, D5212, D5213, D5214, D5225, D5226, D5281, D6194, D6205, D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6245, D6250, D6251, D6252, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.

IMPLANT SUPPORTED RETAINER: D6068, D6069, D6070, D6071, D6072, D6073, D6074, D6075, D6076, D6077, D6194

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- D5211, D5212, D5213, D5214, D5225, D5226, D5281, D6058, D6059, D6060, D6061, D6062, D6063, D6064, D6065, D6066, D6067, D6094, D6205, D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6245, D6250, D6251, D6252, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.

CAST POST AND CORE FOR PARTIALS

D6970	Cast post and core in addition to fixed partial denture retainer.	$34.00
D6971	Cast post as part of fixed partial denture retainer.	$34.00
D6972	Prefabricated post and core in addition to fixed partial denture retainer.	$34.00

OCCLUSAL ADJUSTMENT

D9951	Occlusal adjustment - limited.	$9.00
D9952	Occlusal adjustment - complete.	$45.00

OCCLUSAL ADJUSTMENT: D9951, D9952

- Coverage is considered only when performed in conjunction with periodontal procedures for the treatment of periodontal disease.

Class Number 4

TYPE 1 PROCEDURES

PAYMENT BASIS - Maximum Covered Expense
BENEFIT PERIOD - Calendar Year
For Additional Limitations - See Limitations

		Maximum Covered Expense
ROUTINE ORAL EVALUATION		
D0120	Periodic oral evaluation.	$19.00
D0150	Comprehensive oral evaluation - new or established patient.	$29.00
D0180	Comprehensive periodontal evaluation - new or established patient.	$29.00

COMPREHENSIVE EVALUATION: D0150, D0180

- Coverage is limited to 1 of each of these procedures per 1 provider.
- In addition, D0150, D0180 coverage is limited to 2 of any of these procedures per 1 benefit period.
- D0120, also contribute(s) to this limitation.
- If frequency met, will be considered at an alternate benefit of a D0120 and count toward this frequency.

ROUTINE EVALUATION: D0120

- Coverage is limited to 2 of any of these procedures per 1 benefit period.
- D0150, D0180, also contribute(s) to this limitation.

PROPHYLAXIS (CLEANING) AND FLUORIDE		
D1110	Prophylaxis - adult.	$40.00
D1120	Prophylaxis - child.	$28.00
D1201	Topical application of fluoride (including prophylaxis) - child.	$43.00
D1203	Topical application of fluoride (prophylaxis not included) - child.	$15.00
D1204	Topical application of fluoride (prophylaxis not included) - adult.	$15.00
D1205	Topical application of fluoride (including prophylaxis) - adult.	$55.00

FLUORIDE: D1201, D1203, D1204, D1205

- Coverage is limited to 1 of any of these procedures per 1 benefit period.
- Benefits are considered for persons age 18 and under.
- In addition, D1201, D1205 coverage is limited to 2 of any of these procedures per 1 benefit period.
- D1110, D1120, D4910, also contribute(s) to this limitation.
- The frequency limitation will not be exceeded for either Fluoride or Prophylaxis (cleaning).

PROPHYLAXIS: D1110, D1120

- Coverage is limited to 2 of any of these procedures per 1 benefit period.
- D1201, D1205, D4910, also contribute(s) to this limitation.
- An adult prophylaxis (cleaning) is considered for individuals age 14 and over. A child prophylaxis (cleaning) is considered for individuals age 13 and under. Benefits for prophylaxis (cleaning) are not available when performed on the same date as periodontal procedures.

SPACE MAINTAINERS		
D1510	Space maintainer - fixed - unilateral.	$141.00
D1515	Space maintainer - fixed - bilateral.	$232.00
D1520	Space maintainer - removable - unilateral.	$221.00
D1525	Space maintainer - removable - bilateral.	$270.00
D1550	Re-cementation of space maintainer.	$29.00

SPACE MAINTAINER: D1510, D1515, D1520, D1525

- Coverage is limited to space maintenance for unerupted teeth, following extraction of primary teeth. Allowances include all adjustments within 6 months of placement date.

TYPE 2 PROCEDURES
PAYMENT BASIS - Maximum Covered Expense
BENEFIT PERIOD - Calendar Year
For Additional Limitations - See Limitations

		Maximum Covered Expense
LIMITED ORAL EVALUATION		
D0140	Limited oral evaluation - problem focused.	$20.00
D0170	Re-evaluation - limited, problem focused (established patient; not post-operative visit).	$20.00

LIMITED ORAL EVALUATION: D0140, D0170
- Coverage is allowed for accidental injury only. If not due to an accident, will be considered at an alternate benefit of a D0120 and count towards this frequency.

COMPLETE SERIES OR PANORAMIC FILM		
D0210	Intraoral - complete series (including bitewings).	$41.00
D0330	Panoramic film.	$33.00

COMPLETE SERIES/PANORAMIC FILMS: D0210, D0330
- Coverage is limited to 1 of any of these procedures per 3 year(s).

OTHER XRAYS		
D0220	Intraoral - periapical first film.	$8.00
D0230	Intraoral - periapical each additional film.	$6.00
D0240	Intraoral - occlusal film.	$11.00
D0250	Extraoral - first film.	$13.00
D0260	Extraoral - each additional film.	$11.00

PERIAPICAL FILMS: D0220, D0230
- The maximum amount considered for x-ray films taken on one day will be equivalent to an allowance of a D0210.

BITEWING FILMS		
D0270	Bitewing - single film.	$6.00
D0272	Bitewings - two films.	$12.00
D0274	Bitewings - four films.	$18.00
D0277	Vertical bitewings - 7 to 8 films.	$27.00

BITEWING FILMS: D0270, D0272, D0274
- Coverage is limited to 2 of any of these procedures per 1 benefit period.
- D0277, also contribute(s) to this limitation.
- The maximum amount considered for x-ray films taken on one day will be equivalent to an allowance of a D0210.

VERTICAL BITEWING FILM: D0277
- Coverage is limited to 1 of any of these procedures per 3 year(s).
- The maximum amount considered for x-ray films taken on one day will be equivalent to an allowance of a D0210.

SEALANT		
D1351	Sealant - per tooth.	$15.00

SEALANT: D1351
- Coverage is limited to 1 of any of these procedures per 3 year(s).
- Benefits are considered for persons age 16 and under.
- Benefits are considered on permanent molars only.
- Coverage is allowed on the occlusal surface only.

AMALGAM RESTORATIONS (FILLINGS)		
D2140	Amalgam - one surface, primary or permanent.	$35.00
D2150	Amalgam - two surfaces, primary or permanent.	$44.00
D2160	Amalgam - three surfaces, primary or permanent.	$54.00
D2161	Amalgam - four or more surfaces, primary or permanent.	$64.00

AMALGAM RESTORATIONS: D2140, D2150, D2160, D2161
- Coverage is limited to 1 of any of these procedures per 6 month(s).
- D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394, D9911, also contribute(s) to this limitation.

RESIN RESTORATIONS (FILLINGS)

TYPE 2 PROCEDURES

		Maximum Covered Expense
D2330	Resin-based composite - one surface, anterior.	$43.00
D2331	Resin-based composite - two surfaces, anterior.	$54.00
D2332	Resin-based composite - three surfaces, anterior.	$67.00
D2335	Resin-based composite - four or more surfaces or involving incisal angle (anterior).	$74.00
D2391	Resin-based composite - one surface, posterior.	$47.00
D2392	Resin-based composite - two surfaces, posterior.	$59.00
D2393	Resin-based composite - three surfaces, posterior.	$74.00
D2394	Resin-based composite - four or more surfaces, posterior.	$82.00
D2410	Gold foil - one surface.	$35.00
D2420	Gold foil - two surfaces.	$44.00
D2430	Gold foil - three surfaces.	$54.00

COMPOSITE RESTORATIONS: D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394

- Coverage is limited to 1 of any of these procedures per 6 month(s).
- D2140, D2150, D2160, D2161, D9911, also contribute(s) to this limitation.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.
- Coverage is limited to necessary placement resulting from decay or replacement due to existing unserviceable restorations.

GOLD FOIL RESTORATIONS: D2410, D2420, D2430

- Gold foils are considered at an alternate benefit of an amalgam/composite restoration.

RECEMENT

D2910	Recement inlay, onlay, or partial coverage restoration.	$28.00
D2915	Recement cast or prefabricated post and core.	$14.00
D2920	Recement crown.	$27.00
D6930	Recement fixed partial denture.	$38.00

SEDATIVE FILLING

D2940	Sedative filling.	$26.00

FULL MOUTH DEBRIDEMENT

D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis.	$43.00

FULL MOUTH DEBRIDEMENT: D4355

- Coverage is limited to 1 of any of these procedures per 5 year(s).

PERIODONTAL MAINTENANCE

D4910	Periodontal maintenance.	$44.00

PERIODONTAL MAINTENANCE: D4910

- Coverage is limited to 2 of any of these procedures per 1 benefit period.
- D1110, D1120, D1201, D1205, also contribute(s) to this limitation.
- Coverage is contingent upon evidence of full mouth active periodontal therapy. Benefits are not available if performed on the same date as any other periodontal procedure.

PALLIATIVE

D9110	Palliative (emergency) treatment of dental pain - minor procedure.	$29.00

PALLIATIVE TREATMENT: D9110

- Not covered in conjunction with other procedures, except diagnostic x-ray films.

PROFESSIONAL CONSULT/VISIT/SERVICES

D9310	Consultation (diagnostic service provided by dentist or physician other than practitioner providing treatment).	$30.00
D9430	Office visit for observation (during regularly scheduled hours) - no other services performed.	$20.00
D9440	Office visit - after regularly scheduled hours.	$36.00
D9930	Treatment of complications (post-surgical) - unusual circumstances, by report.	$22.00

CONSULTATION: D9310

- Coverage is limited to 1 of any of these procedures per 1 provider.

OFFICE VISIT: D9430, D9440

TYPE 2 PROCEDURES

Maximum Covered Expense

- Procedure D9430 is allowed for accidental injury only. Procedure D9440 will be allowed on the basis of services rendered or visit, whichever is greater.

MISCELLANEOUS

D2951 Pin retention - per tooth, in addition to restoration. $13.00

D9911 Application of desensitizing resin for cervical and/or root surfaces, per tooth. $43.00

DESENSITIZATION: D9911

- Coverage is limited to 1 of any of these procedures per 6 month(s).
- D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394, also contribute(s) to this limitation.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.
- Coverage is limited to necessary placement resulting from decay or replacement due to existing unserviceable restorations.

EYE CARE EXPENSE BENEFITS

Class Number 1

If an Insured under this section incurs Covered Expenses, we will pay benefits as stated below. The Insured may use a Participating Provider or a Non-Participating Provider. The Insured has the freedom to choose any provider at all times.

AMOUNT PAYABLE. The Amount Payable for Covered Expenses performed by a Participating Provider is the amount agreed to by the Participating Provider and the Company for the services.

The Amount Payable for Covered Expenses performed by a Non-Participating Provider is the lesser of:

a. the Non-Participating Provider's charge, or

b. the Maximum Covered Expense for such services or supplies shown in the Schedule of Eye Care Services.

DEDUCTIBLE AMOUNT. The Deductible Amount shown in the Schedule of Benefits is an amount of Covered Expenses for which no benefits are payable. It applies separately to the Covered Expenses incurred by each Insured. Benefits will be paid only for those Covered Expenses that are over the deductible amount.

PARTICIPATING AND NON-PARTICIPATING PROVIDERS. A Participating Provider agrees to provide services and supplies to our insureds at a discounted fee. A Non-Participating Provider is any other provider.

COVERED EXPENSES. Covered expenses are the eye care expenses incurred by an Insured for services or supplies up to the Maximum Covered Expense shown in the Schedule of Eye Care Services, for each service.

EYE CARE SUPPLIES. Eye care supplies includes all services listed on the Schedule of Eye Care Services except for any services provided for Eye Care Examinations.

REQUEST FOR SERVICES. An Insured may request services from a Participating Provider by scheduling an appointment and notifying the provider’s office that the Insured has coverage for services provided by that office as a Participating Provider. Should the Insured receive services from a Participating Provider without such notification, then for the purposes of those services provided to the Insured, the provider will be considered a Non-Participating Provider, and the benefits available will be limited to those for a Non-Participating Provider.

ASSIGNMENT OF BENEFITS. When services and supplies are performed or furnished by a Participating Provider, benefits will be paid to the Participating Provider. When services are performed by a Non-Participating Provider, benefits will be paid to the Insured.

EXTENSION OF BENEFITS. This section provides an extension of benefits for eye care supplies if the policy terminates. To be eligible for this extension, the supply must have been prescribed prior to the termination of the policy and must be received within six months after the policy terminates.

EXPENSES INCURRED. An expense is incurred at the time a service is rendered or a supply item furnished.

LIMITATIONS. Covered Expenses will not include and no benefits will be payable for expenses incurred for:

1. eye exam more than once in any 12 month period.
2. medical or surgical treatment of the eyes.
3. services for which a claim is filed more than 180 days after completion of the service.

SCHEDULE OF EYE CARE SERVICES

The following is a complete list of eye care services for benefits payable under this section. No benefits are payable for a service not listed.

SERVICE	***MAXIMUM COVERED EXPENSE***	
	Participating Provider	*Non-Participating Provider*
Eye Examination *(All lenses are per pair)*	Covered in Full	Up to $ 47.00

Class Number 2

If an Insured under this section incurs Covered Expenses, we will pay benefits as stated below. The Insured may use a Participating Provider or a Non-Participating Provider. The Insured has the freedom to choose any provider at all times.

AMOUNT PAYABLE. The Amount Payable for Covered Expenses performed by a Participating Provider is the amount agreed to by the Participating Provider and the Company for the services.

The Amount Payable for Covered Expenses performed by a Non-Participating Provider is the lesser of:

a. the Non-Participating Provider's charge, or

b. the Maximum Covered Expense for such services or supplies shown in the Schedule of Eye Care Services.

DEDUCTIBLE AMOUNT. The Deductible Amount shown in the Schedule of Benefits is an amount of Covered Expenses for which no benefits are payable. It applies separately to the Covered Expenses incurred by each Insured. Benefits will be paid only for those Covered Expenses that are over the deductible amount.

PARTICIPATING AND NON-PARTICIPATING PROVIDERS. A Participating Provider agrees to provide services and supplies to our insureds at a discounted fee. A Non-Participating Provider is any other provider.

COVERED EXPENSES. Covered expenses are the eye care expenses incurred by an Insured for services or supplies up to the Maximum Covered Expense shown in the Schedule of Eye Care Services, for each service.

EYE CARE SUPPLIES. Eye care supplies includes all services listed on the Schedule of Eye Care Services except for any services provided for Eye Care Examinations.

REQUEST FOR SERVICES. An Insured may request services from a Participating Provider by scheduling an appointment and notifying the provider’s office that the Insured has coverage for services provided by that office as a Participating Provider. Should the Insured receive services from a Participating Provider without such notification, then for the purposes of those services provided to the Insured, the provider will be considered a Non-Participating Provider, and the benefits available will be limited to those for a Non-Participating Provider.

ASSIGNMENT OF BENEFITS. When services and supplies are performed or furnished by a Participating Provider, benefits will be paid to the Participating Provider. When services are performed by a Non-Participating Provider, benefits will be paid to the Insured.

EXTENSION OF BENEFITS. This section provides an extension of benefits for eye care supplies if the policy terminates. To be eligible for this extension, the supply must have been prescribed prior to the termination of the policy and must be received within six months after the policy terminates.

EXPENSES INCURRED. An expense is incurred at the time a service is rendered or a supply item furnished.

LIMITATIONS. Covered Expenses will not include and no benefits will be payable for expenses incurred for:

1. eye exam more than once in any 12 month period.
2. medical or surgical treatment of the eyes.
3. services for which a claim is filed more than 180 days after completion of the service.

SCHEDULE OF EYE CARE SERVICES

The following is a complete list of eye care services for benefits payable under this section. No benefits are payable for a service not listed.

SERVICE	***MAXIMUM COVERED EXPENSE***	
	Participating Provider	*Non-Participating Provider*
Eye Examination *(All lenses are per pair)*	Covered in Full	Up to $ 47.00

Class Number 3

If an Insured under this section incurs Covered Expenses, we will pay benefits as stated below. The Insured may use a Participating Provider or a Non-Participating Provider. The Insured has the freedom to choose any provider at all times.

AMOUNT PAYABLE. The Amount Payable for Covered Expenses performed by a Participating Provider is the amount agreed to by the Participating Provider and the Company for the services.

The Amount Payable for Covered Expenses performed by a Non-Participating Provider is the lesser of:

a. the Non-Participating Provider's charge, or

b. the Maximum Covered Expense for such services or supplies shown in the Schedule of Eye Care Services.

DEDUCTIBLE AMOUNT. The Deductible Amount shown in the Schedule of Benefits is an amount of Covered Expenses for which no benefits are payable. It applies separately to the Covered Expenses incurred by each Insured. Benefits will be paid only for those Covered Expenses that are over the deductible amount.

PARTICIPATING AND NON-PARTICIPATING PROVIDERS. A Participating Provider agrees to provide services and supplies to our insureds at a discounted fee. A Non-Participating Provider is any other provider.

COVERED EXPENSES. Covered expenses are the eye care expenses incurred by an Insured for services or supplies up to the Maximum Covered Expense shown in the Schedule of Eye Care Services, for each service.

EYE CARE SUPPLIES. Eye care supplies includes all services listed on the Schedule of Eye Care Services except for any services provided for Eye Care Examinations.

REQUEST FOR SERVICES. An Insured may request services from a Participating Provider by scheduling an appointment and notifying the provider’s office that the Insured has coverage for services provided by that office as a Participating Provider. Should the Insured receive services from a Participating Provider without such notification, then for the purposes of those services provided to the Insured, the provider will be considered a Non-Participating Provider, and the benefits available will be limited to those for a Non-Participating Provider.

ASSIGNMENT OF BENEFITS. When services and supplies are performed or furnished by a Participating Provider, benefits will be paid to the Participating Provider. When services are performed by a Non-Participating Provider, benefits will be paid to the Insured.

EXTENSION OF BENEFITS. This section provides an extension of benefits for eye care supplies if the policy terminates. To be eligible for this extension, the supply must have been prescribed prior to the termination of the policy and must be received within six months after the policy terminates.

EXPENSES INCURRED. An expense is incurred at the time a service is rendered or a supply item furnished.

LIMITATIONS. Covered Expenses will not include and no benefits will be payable for expenses incurred for:

1. eye exam more than once in any 12 month period.
2. medical or surgical treatment of the eyes.
3. services for which a claim is filed more than 180 days after completion of the service.

SCHEDULE OF EYE CARE SERVICES

The following is a complete list of eye care services for benefits payable under this section. No benefits are payable for a service not listed.

SERVICE	***MAXIMUM COVERED EXPENSE***	
	Participating Provider	*Non-Participating Provider*
Eye Examination *(All lenses are per pair)*	Covered in Full	Up to $ 47.00

Class Number 4

If an Insured under this section incurs Covered Expenses, we will pay benefits as stated below. The Insured may use a Participating Provider or a Non-Participating Provider. The Insured has the freedom to choose any provider at all times.

AMOUNT PAYABLE. The Amount Payable for Covered Expenses performed by a Participating Provider is the amount agreed to by the Participating Provider and the Company for the services.

The Amount Payable for Covered Expenses performed by a Non-Participating Provider is the lesser of:

a. the Non-Participating Provider's charge, or

b. the Maximum Covered Expense for such services or supplies shown in the Schedule of Eye Care Services.

DEDUCTIBLE AMOUNT. The Deductible Amount shown in the Schedule of Benefits is an amount of Covered Expenses for which no benefits are payable. It applies separately to the Covered Expenses incurred by each Insured. Benefits will be paid only for those Covered Expenses that are over the deductible amount.

PARTICIPATING AND NON-PARTICIPATING PROVIDERS. A Participating Provider agrees to provide services and supplies to our insureds at a discounted fee. A Non-Participating Provider is any other provider.

COVERED EXPENSES. Covered expenses are the eye care expenses incurred by an Insured for services or supplies up to the Maximum Covered Expense shown in the Schedule of Eye Care Services, for each service.

EYE CARE SUPPLIES. Eye care supplies includes all services listed on the Schedule of Eye Care Services except for any services provided for Eye Care Examinations.

REQUEST FOR SERVICES. An Insured may request services from a Participating Provider by scheduling an appointment and notifying the provider’s office that the Insured has coverage for services provided by that office as a Participating Provider. Should the Insured receive services from a Participating Provider without such notification, then for the purposes of those services provided to the Insured, the provider will be considered a Non-Participating Provider, and the benefits available will be limited to those for a Non-Participating Provider.

ASSIGNMENT OF BENEFITS. When services and supplies are performed or furnished by a Participating Provider, benefits will be paid to the Participating Provider. When services are performed by a Non-Participating Provider, benefits will be paid to the Insured.

EXTENSION OF BENEFITS. This section provides an extension of benefits for eye care supplies if the policy terminates. To be eligible for this extension, the supply must have been prescribed prior to the termination of the policy and must be received within six months after the policy terminates.

EXPENSES INCURRED. An expense is incurred at the time a service is rendered or a supply item furnished.

LIMITATIONS. Covered Expenses will not include and no benefits will be payable for expenses incurred for:

1. eye exam more than once in any 12 month period.
2. medical or surgical treatment of the eyes.
3. services for which a claim is filed more than 180 days after completion of the service.

SCHEDULE OF EYE CARE SERVICES

The following is a complete list of eye care services for benefits payable under this section. No benefits are payable for a service not listed.

SERVICE	***MAXIMUM COVERED EXPENSE***	
	Participating Provider	*Non-Participating Provider*
Eye Examination *(All lenses are per pair)*	Covered in Full	Up to $ 47.00

COORDINATION OF BENEFITS

This section applies if an Insured person has dental coverage under more than one Plan definition below. All benefits provided under this policy are subject to this section.

EFFECT ON BENEFITS. The Order of Benefit Determination rules below determine which Plan will pay as the primary Plan. If all or any part of an Allowable Expense under this Plan is an Allowable Expense under any other Plan, then benefits will be reduced so that, when they are added to benefits payable under any other Plan for the same service or supply, the total does not exceed 100% of the total Allowable Expense.

If another Plan is primary and this Plan is considered secondary, the amount by which benefits have been reduced during the Claim Determination Period will be used by us to pay the Allowable Expenses not otherwise paid which were incurred by you in the same Claim Determination Period. We will determine our obligation to pay for Allowable Expenses as each claim is submitted, based on all claims submitted in the current Claim Determination Period.

DEFINITIONS. The following apply only to this provision of the policy.

1. "Plan" refers to the group policy and any of the following plans, whether insured or uninsured, providing benefits for dental services or supplies:

    a. Any group or blanket insurance policy.

    b. Any group Blue Cross, group Blue Shield, or group prepayment arrangement.

    c. Any labor/management, trusteed plan, labor organization, employer organization, or employee organization plan, whether on an insured or uninsured basis.

    d. Any coverage under a governmental plan that allows coordination of benefits, or any coverage required or provided by law. This does **not** include a state plan under Medicaid (TitleXVIII and XIX of the Social Security Act as enacted or amended). It also does not include any plan whose benefits by law are excess to those of any private insurance program or other non-governmental program.

2. "Plan" does **not** include the following:

    a. Individual or family benefits provided through insurance contracts, subscriber contracts, coverage through individual HMOs or other prepayment arrangements.

    b. Coverages for school type accidents only, including athletic injuries.

3. "Allowable Expense" refers to any necessary, reasonable and customary item of expense at least a portion of which is covered under at least one of the Plans covering the Insured person for whom that claim is made. When a Plan provides services rather than cash payments, the reasonable cash value of each service will be both an Allowable Expense and a benefit paid. Benefits payable under another Plan include benefits that would have been payable had a claim been made for them.

4. "Claim Determination Period" refers to a Benefit Period, but does not include any time during which a person has no coverage under this Plan.

5. "Custodial Parent" refers to a parent awarded custody of a minor child by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than half of the calendar year without regard to any temporary visitation.

ORDER OF BENEFIT DETERMINATION. When two or more Plans pay benefits, the rules for determining the order of payment are as follows:

1. A Plan that does not have a coordination of benefits provision is always considered primary and will pay benefits first.

2. If a Plan also has a coordination of benefits provision, the first of the following rules that describe which Plan pays its benefits before another Plan is the rule to use:

    a. The benefits of a Plan that covers a person as an employee, member or subscriber are determined before those of a Plan that covers the person as a dependent.

    b. If a Dependent child is covered by more than one Plan, then the primary Plan is the Plan of the parent whose birthday is earlier in the year if:

        i. the parents are married;

        ii. the parents are not separated (whether or not they ever have been married); or

        iii. a court decree awards joint custody without specifying that one party has the responsibility to provide dental and/or eye care coverage.

        If both parents have the same birthday, the Plan that covered either of the parents longer is primary.

    c. If the Dependent child is covered by divorced or separated parents under two or more Plans, benefits for that Dependent child will be determined in the following order:

        i. the Plan of the Custodial Parent;

        ii. the Plan of the spouse of the Custodial Parent;

        iii. the Plan of the non-Custodial Parent; and then

        iv. the Plan of the spouse of the non-Custodial Parent.

        However, if the specific terms of a court decree establish a parent's responsibility for the child's dental and/or eye care expenses and the Plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to Claim Determination Periods or Benefit Periods commencing after the Plan is given notice of the court decree.

    d. The benefits of a Plan that cover a person as an employee who is neither laid-off nor retired (or as that employee's dependent) are determined before those of a Plan that covers that person as a laid-off or retired employee (or as that employee's dependent). If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule will be ignored.

    e. If a person whose coverage is provided under a right of continuation provided by a federal or state law also is covered under another Plan, the Plan covering the person as an employee, member, subscriber or retiree (or as that person's dependent) is primary, and the continuation coverage is secondary. If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule will be ignored.

    f. The benefits of a Plan that has covered a person for a longer period will be determined first.

If the preceding rules do not determine the primary Plan, the allowable expenses shall be shared equally between the Plans meeting the definition of Plan under this provision. In addition, this Plan will not pay more than what it would have paid had it been primary.

RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION. We may without your consent and notice to you:

1. Release any information with respect to your coverage and benefits under the policy; and

2. Obtain from any other insurance company, organization or person any information with respect to your coverage and benefits under another Plan.

You must provide us with any information necessary to coordinate benefits.

FACILITY OF PAYMENT. When other Plans make payments that should have been made under this Plan according to the above terms, we will, at our discretion, pay to any organizations making these payments any amounts that we decide will satisfy the intent of the above terms. Amounts paid in this way will be benefits paid under this Plan. We will not be liable to the extent of these payments.

RIGHT OF RECOVERY. When we make payments for Allowable Expenses in excess of the amount that will satisfy the intent of the above terms, we will recover these payments, to the extent of the excess, from any persons or organizations to or for whom these payments were made. The amount of the payments made includes the reasonable cash value of any benefits provided in the form of services.

GENERAL PROVISIONS

NOTICE OF CLAIM. Written notice of a claim must be given to us within 30 days after the incurred date of the services provided for which benefits are payable.

Notice must be given to us at our Home Office, or to one of our agents. Notice should include the Policyholder's name, Insured's name, and policy number. If it was not reasonably possible to give written notice within the 30 day period stated above, we will not reduce or deny a claim for this reason if notice is filed as soon as is reasonably possible.

CLAIM FORMS. When we receive the notice of a claim, we will send the claimant forms for filing proof of loss. If these forms are not furnished within 15 days after the giving of such notice, the claimant will meet our proof of loss requirements by giving us a written statement of the nature and extent of loss within the time limit for filing proofs of loss.

PROOF OF LOSS. Written proof of loss must be given to us within 90 days after the incurred date of the services provided for which benefits are payable. If it is impossible to give written proof within the 90-day period, we will not reduce or deny a claim for this reason if the proof is filed as soon as is reasonably possible.

TIME OF PAYMENT. We will pay all benefits immediately when we receive due proof. Any balance remaining unpaid at the end of any period for which we are liable will be paid at that time.

PAYMENT OF BENEFITS. All benefits will be paid to the Insured unless you authorize us in writing to make payment to the Provider providing the services or supplies.

FACILITY OF PAYMENT. If an Insured or beneficiary is not capable of giving us a valid receipt for any payment or if benefits are payable to the estate of the Insured, then we may, at our option, pay the benefit up to an amount not to exceed $5,000, to any relative by blood or connection by marriage of the Insured who is considered by us to be equitably entitled to the benefit.

Any equitable payment made in good faith will release us from liability to the extent of payment.

PROVIDER-PATIENT RELATIONSHIP. The Insured may choose any Provider who is licensed by the law of the state in which treatment is provided within the scope of their license. We will in no way disturb the provider-patient relationship.

LEGAL PROCEEDINGS. No legal action can be brought against us until 60 days after the Insured sends us the required proof of loss. No legal action against us can start more than five years after proof of loss is required.

INCONTESTABILITY. Any statement made by the Policyholder to obtain the Policy is a representation and not a warranty. No misrepresentation by the Policyholder will be used to deny a claim or to deny the validity of the Policy unless:

1. The Policy would not have been issued if we had known the truth; and

2. We have given the Policyholder a copy of a written instrument signed by the Policyholder that contains the misrepresentation.

The validity of the Policy will not be contested after it has been in force for one year, except for nonpayment of premiums or fraudulent misrepresentations.

WORKER'S COMPENSATION. The coverage provided under the Policy is not a substitute for coverage under a workmen's compensation or state disability income benefit law and does not relieve the Policyholder of any obligation to provide such coverage.

GENERAL PROVISIONS *(CONTINUED)*

CONFORMITY WITH LAW. Any policy provision that conflicts with the laws of the state in which the policy is issued, when the policy is issued, is automatically changed to meet the minimum requirements of those laws.

ENTIRE CONTRACT. The policy and the application of the Policyholder constitute the entire contract between the parties. A copy of the Policyholder's application is attached to the policy when issued. All statements made by the Policyholder or an Insured will, in the absence of fraud, be considered representations and not warranties. No statement made to obtain insurance will be used to avoid the insurance or reduce the benefits of this policy unless it is in a written application signed by the Policyholder or Insured. A copy of this must have been given to the Policyholder or Insured.

No change in this policy will be valid unless approved in writing by one of our officers and given to the Policyholder for attachment to the policy. No agent has the authority to change this policy or waive any of its provisions. Any change in this policy will be valid even though an Insured may not have agreed to it.

INSURANCE DATA. The Policyholder will furnish, at our request, data necessary to administer this policy. The data will include, but not be limited to data:

i. necessary to calculate premiums;

ii. necessary to determine a person's effective date or termination date of insurance;

iii. necessary to determine the proper coverage level of insurance.

We shall have the right to inspect any of the Policyholder's records we find necessary to properly administer this policy. Any inspections will be at a time and place convenient to the Policyholder.

We will not refuse to insure a person who is eligible to be insured just because the Policyholder fails or errs in giving us the data necessary to include that person for coverage. An Insured's insurance will not stay in force nor an amount of insurance be continued after the termination date, according to the Conditions for Insurance, because the Policyholder fails or errors in giving us the necessary data concerning an Insured's termination.

CERTIFICATES. We will issue certificates to the Policyholder showing the coverage under the policy. The Policyholder will distribute a certificate to each insured Member. If the terms of the certificate differ from the policy, the terms stated in the policy will govern.

PARTICIPATION REQUIREMENTS. There are two requirements that must be met in order for the policy to be placed in force, and to remain in force:

a. a certain percentage of all Members qualified for insurance must be insured at all times; and

b. a certain number of Insureds must be insured at all times.

The Participation Requirements are as follows:

Percentage of Members-	100%
Number of Members-	415

TERMINATION OF THE POLICY. The Policyholder may terminate this policy as of any Premium Due Date by giving us written notice before that date.

We may terminate this policy on the earlier of:

1. any Premium Due Date if the participation of Insureds and/or Dependents does not meet the requirements in "Conditions For Insurance." Written notice of termination of insurance must be given to the Policyholder at least 45 days before the date of termination.

2. any Premium Due Date on or after the first policy year, for reasons other than lack of participation. Written notice of termination of insurance must be given to the Policyholder at least 60 days before the date of termination.

If any premium is not paid when due, this policy will automatically be terminated as of the Premium Due Date, except as stated below.

GRACE PERIOD. This policy has a 60 day grace period. This means that if a renewal premium is not paid on or before the date it is due, it may be paid during the following 60 days. During the grace period, the policy will stay in force. If the Policyholder has not sent us a written request to terminate the policy and a premium is not paid by the end of the grace period, the policy will terminate at the end of the grace period. If the Policyholder gives us written notice of termination before the Premium Due Date, the policy will be terminated as of the date requested. The Policyholder will be liable for any unpaid premium for the time this policy was in force, including the grace period.

CONSIDERATION. This policy is issued to the Policyholder in consideration of the application and the payment of premiums specified in this policy.

TERMS AND CONDITIONS. Payment of any benefit under this policy is subject to the definitions and all other terms of this policy pertinent to the benefit.

CLAIMS REVIEW PROCEDURES
AS REQUIRED UNDER
EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 (ERISA)

The following provides information regarding the claims review process and your rights to request a review of any part of a claim that is denied. Please note that certain state laws may also require specified claims payment procedures as well as internal appeal procedures and/or independent external review processes. Therefore, in addition to the review procedures defined below, you may also have additional rights provided to you under state law. If your state has specific grievance procedures, an additional notice specific to your state will also be included within the group policy and your certificate.

CLAIMS FOR BENEFITS

Claims may be submitted by mailing the completed claim form along with any requested information to:

Dental Claims:
Ameritas Life Insurance Corp.
PO Box 82520
Lincoln, NE 68501

Eye Care Claims:
Vision Service Plan
Attn: Out-of-Network Provider Claims
P.O. Box 997105
Sacramento, CA 95899-7105

NOTICE OF DECISION OF CLAIM

We will evaluate your claim promptly after we receive it. We will provide you written notice regarding the payment under the claim within at least 30 calendar days following receipt of the claim. This period may be extended for an additional 15 days, provided that we have determined that an extension is necessary due to matters beyond our control, and notify you, prior to the expiration of the initial 30-day period, of the circumstances requiring the extension of time and the date by which we expect to render a decision. If the extension is due to your failure to provide information necessary to decide the claim, the notice of extension shall specifically describe the required information we need to decide the claim.

If we request additional information, you will have 45 days to provide the information. If you do not provide the requested information within 45 days, we may decide your claim based on the information we have received.

If we deny any part of your claim, you will receive a written notice of denial containing:

a. The reasons for our decision.
b. Reference to the parts of the Group Policy on which our decision is based.
c. Reference to any internal rule or guideline relied upon in making our decision, along with your right to receive a copy of these guidelines, free of charge, upon request.
d. A statement that you may request an explanation of the scientific or clinical judgment we relied upon to exclude expenses that are experimental or investigational, or are not necessary or accepted according to generally accepted standards of dental and/or eye care practice.
e. A description of any additional information needed to support your claim and why such information is necessary.
f. Information concerning your right to a review of our decision.
g. Information concerning your right to bring a civil action for benefits under section 502(a) of ERISA following an adverse benefit determination on review.

REVIEW PROCEDURE

If all or part of a claim is denied, you may request a review. You must request a review in writing within 180 days after receiving notice of the denial.

You may send us written comments or other items to support your claim. You may review and receive copies of any non-privileged information that is relevant to your request for review. There will be no charge for such copies. You may request the names of the experts we consulted who provided advice to us about your claim.

The review will be conducted by the Plan's named fiduciary and will be someone other than the person who denied the initial claim and will not be subordinate to that person. The person conducting the review will not give deference to the initial denial decision. If the denial was based in whole or in part on a medical judgment, including determinations with regard to whether a service was considered experimental, investigational, and/or not medically necessary, the person conducting the review will consult with a qualified health care professional. This health care professional will be someone other than the person who made the original judgment and will not be subordinate to that person. Our review will include any written comments or other items you submit to support your claim.

We will review your claim promptly after we receive your request. Within at least 60 days after we receive your request for review we will send you a written decision on review.

If we deny any part of your claim on review, you will receive a written notice of denial containing:

a. The reasons for our decision.
b. Reference to the parts of the Group Policy on which our decision is based.
c. Reference to any internal rule or guideline relied upon in making our decision along with your right to receive a copy of these guidelines, free of charge, upon request.
d. Information concerning your right to receive, free of charge, copies of non-privileged documents and records relevant to your claim.
e. A statement that you may request an explanation of the scientific or clinical judgement we relied upon to exclude expenses that are experimental or investigational, or are not necessary or accepted according to generally accepted standards of dental and/or eye care practice.
f. Information concerning your right to bring a civil action for benefits under section 502(a) of ERISA.

Certain state laws also require specified internal appeal procedures and/or external review processes. In addition to the review procedures defined above, you may also have additional rights provided to you under state law. Please contact your state insurance regulatory agency for assistance. In any event, you need not exhaust such state law procedures prior to bringing civil action under Section 502(a) of ERISA.

Any request for claim review should be sent to:

Quality Control, P.O. Box 82629, Lincoln, NE 68501-2629.

Application is Hereby Made to

AMERITAS LIFE INSURANCE CORP.

by: UNITED SERVICE ASSOCIATION
FOR HEALTHCARE

whose main office address is: 1747 PENNSYLVANIA AVE NW STE 1000
WASHINGTON, DC 20006-4636

for Group Policy No. 10-350300

This group policy is hereby approved. Its terms are hereby accepted.

This Acceptance Application is made in duplicate. One is attached to the policy. The other part has been returned to the Company.

It is agreed that this application supersedes any previous application for the group policy.

UNITED SERVICE ASSOCIATION
FOR HEALTHCARE
(Full or Corporate Name of Applicant)

Dated at_____By_____
(Signature and Title)

On_____, 20__ Witness_____
(To be signed by Resident Agent where required by law)

This copy is to Remain Attached to the Policy

We have received your filing regarding the above named association/ discretionary group. To determine if this organization is a qualified group under our statutes, please provide the answers to the following questions:

1. Name and address of the group.
   United Service Association For Health Care
   1901 N. Highway 360
   Grand Prairie, TX 75050

2. Is this group incorporated? If so, give state of incorporation.
   United Service Association For Health Care (USA+) was charted under the chartered under the provisions of the District of Columbia Non-Profit Corporation Act (D.C. Code, 1981 Edition, Title 29, Chapter 5) by the Department of Consumer and Regulatory Affairs, Washington, D.C. on April 15, 1983.

3. Is there a current office in Arkansas?
   NO

4. Does the Arkansas part of the organization have any officers, committees, or chapters? If so, give details.
   No

5. Are annual dues charged? If so, specify amount.
   Dues vary from $0 to $500 based on the membership level.

6. What are the specific activities of the organization?
   - **Assist charitable, educational and social welfare organizations in the conduct of similar activities: The association donates $2 of the membership dues collected from each member each month in order to support organizations that have purpose to discover new health treatment solutions that are effective and affordable, improve the level of treatment provided to patients, provide assistance for those individuals with handicaps and to provide assistance to educational organizations. To date, the foundation has donated almost $7 million to organizations such as St. Jude's, United Cerebral Palsy and Juvenile Diabetes Research Foundation, scholarships for students attending the University of Texas School of Nursing, to name a few. A list of grand and award recipients can be found on the association's website at www.usahc.com.**

   - **Engage in nonpartisan research, study and analysis for the benefit of the general public regarding the health care system of the United States and to publish the results of such research.**

   - **Prepare educational materials, sponsor forums and conduct educational activities in support of the general purposes of the corporation;**

7. What benefits are provided to the members in addition to insurance? PLEASE ATTACH BROCHURES ON THE BENEFITS.
   The member receives advocacy benefits, which is included in the basic membership in the association. Basic benefits also include a Benefits Protector program, which

helps cushion the impact of economic downturns that occur. Should a member lose their job through no fault of their own, membership dues are waived and membership benefits continue for three (3) months.

8. What qualifies an individual for membership?
   Membership in USA+ is open to employers and employees (including persons who are small business owners, self-employed or retired) who are interested in and supportive of the purposes for which the Corporation was organized, which include improving national health policy issues and providing practical solutions for members. Board meetings are held bi-annually and all members have voting rights as established by the Bylaws.

9. How are members recruited? If by mailing list, advise the source of this list.
   Members are recruited via the internet and by independent contractors.

10. Attach a copy of the organization by-laws.
    Attached as requested

11. Also, enclose a list of dues paying members residing in Arkansas with full addresses. If the organization considers this privileged information, we will treat it as such and once it has served our purpose, it will be destroyed.
    Attached as requested

12. Please attach a copy of the organization's most recent financial statement.
    Attached as requested

13. Does the organization receive any compensation of any kind from the insurer issuing contracts to its members?
    NO

Approval of the organization as a qualified group for insurance purposes will be determined upon receipt of your reply.